IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

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CHERYL AUSTIN, ADMX, ESTATE OF SONOMA DAVIS,	:	
Plaintiff,	:	
vs.	:	CAUSE NO. 538,701
METRO HEALTH MEDICAL CENTER, ET AL.,	:	
Defendants.	:	

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DEPONENT: JAMES M. GREENBERG, M.D.

OCTOBER 10, 2005

8:45 A.M.

REPORTED BY:
Heidi L. Constable, RPR, RMR

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Deposition of JAMES M. GREENBERG, M.D., a witness herein, taken by the Plaintiff as upon cross-examination pursuant to agreement of counsel and stipulations hereinafter set forth, at the offices of Kinko's, 51 East Fifth Street, Cincinnati, Ohio at 8:45 a.m., on Monday, October 10, 2005, before Heidi L. Constable, RPR, RMR, a Notary Public within and for the State of Ohio.

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APPEARANCES:

On behalf of the Plaintiff
(via teleconference)

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On behalf of the Defendants

COLLEEN H. PETRELLO, ESQ.
Sutter, O'Connell, Mannion & Farchione
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1301 East Ninth Street
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STIPULATIONS

It is stipulated by and between counsel for the respective parties that the deposition of JAMES M. GREENBERG, M.D., a witness herein, may be taken at this time by the Plaintiff as upon cross-examination, pursuant to the Ohio Rules of Civil Procedure and pursuant to agreement of counsel; deposition may be taken in stenotypy by the Notary Public and court reporter and transcribed by her out of the presence of the witness; that the deposition is to be submitted to the witness for his examination and signature; and that signature is not waived.

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EXHIBITS

(NO EXHIBITS WERE MARKED)

JAMES M. GREENBERG, M.D.,

of lawful age, as having been duly sworn, was examined and testified as follows:

CROSS-EXAMINATION

BY MS. KOLIS:

Q. Doctor, for the record could you please state your name and your professional address.

A. Certainly. James M. Greenberg. My professional address is Cincinnati Children's Hospital Medical Center, 3333 Burnet Avenue, B-U-R-N-E-T, Cincinnati, Ohio 45229.

Q. Okay. Doctor, for identification purposes, for the record my name is Donna Kolis, I am the attorney that has been retained to represent the Estate of Sonoma Davis. Today my purpose in taking your deposition is to discover the opinions as much as possible that you hold that you'll be rendering at the trial of that lawsuit and the factual medical bases for the same.

We have agreed, that being myself and Ms. Petrello to do this deposition by video conferencing. As you are probably aware from your own personal experience there are on occasions technical difficulties with this kind of proceeding.

For instance, I now have completely lost the view of yourself or Ms. Petrello. Did you guys move -- was there any movement of your monitor?

MS. PETRELLO: Let's go off the record.

(Discussion off the record)

BY MS. KOLIS:

Q. Okay. I think we're good now. Doctor, the other complications besides visuals that can occur is there's sometimes a slight time delay between a question being completed and you being able to hear it, so I'd ask that you, to the best of our abilities, attempt not to speak over one another so that the court reporter can accurately take down the full and complete questions as well as, of course, more importantly, your full and complete answers. Can I secure that agreement from you?

A. Yes.

Q. Okay. All right. We're going to go through the typical administrative housekeeping part of the deposition first. Doctor, it's my understanding from depositions which you've given pretty recently that your current hourly charge is $300; is that correct?

A. Yes, it is.

Q. Okay. You will, of course, at the conclusion of today's deposition prepare a bill for the time that I've spent with you, forward it to Ms. Petrello, and I'll make certain that it is paid in a timely manner. Doctor, when were you initially contacted in this case?

A. I believe it was in the spring of 2004, but I'd have to look at my notes to be certain.

Q. Okay. And, like I said, the next easy part, prior to you entering the room, Ms. Petrello kindly gave me a brief inventory of what is being represented to be your file. I understand that you didn't bring all of the medical records, although they would be available. However, along those lines, do you keep a correspondence file?

A. I keep it with the regular file that I maintain for the case. I have that right here in front of me.

Q. Great. With reference to your correspondence file, does that refresh your recollection as to when you were initially contacted?

A. The first letter I have is dated January 10, 2004.

Q. Okay. And by whom were you contacted, Doctor?

A. By Ms. Petrello.

Q. Okay. Doctor, may I inquire, had you ever had an opportunity to work with Colleen Petrello or any of the attorneys at Sutter, O'Connell, Mannion & Farchione prior to that occasion?

A. No.

Q. Okay. My understanding from reading other testimony that you have offered is that in the past three years you have exclusively testified for physicians. Is my understanding correct?

A. I have once testified at a deposition for the defense. I can't tell you right now whether that was more than three years ago or not. It was within the last three or four years.

Q. Doctor, I may have misheard or you may have misspoke. Did you mean to indicate to me that you testified once for a patient, and I believe that patient by testimony was in Connecticut?

A. Yes.

Q. Not once for the defense, once for a patient, correct?

A. Correct. I'm sorry. Yes.

Q. Okay. Well, it's pretty early in the morning so we're allowed to misspeak. All right. And initially, Doctor, what information were you provided with regarding this case?

A. I was provided with maternal records of Cheryl Austin as well as infant records of Sonoma Davis.

Q. All right. At that time -- was those the only materials that you were given at that time?

A. Yes.

Q. Okay. I'm not going to ask you to read all of your correspondence, could you read at least into the record that preliminary piece of correspondence.

A. Do you want to hear the whole letter or just the records?

Q. The whole letter, if you don't mind.

A. Okay. Dear Dr. Greenberg, Thank you for agreeing to review the above-captioned matter on behalf of our client, Metro Health Medical Center. For your review I have enclosed a copy of the following medical record/maternal records: One, Northeast Ohio Neighborhood Health Services 12/17/02 to 5/5/03. Two, Cuyahoga County EMS 5/12/03. Three,

Metro Health Medical Center admission 5/12/03 to 5/18/03. And four, Metro Health Medical Center EPIC records 5/12/03 to 6/2/03. Infant records: One, Metro Health Medical Center admission 5/12/03 to 7/1/03. And two, University Hospitals of Cleveland one through five.

MS. PETRELLO: Those are volumes.

A. Yeah. Please review the materials provided and contact me directly of (216) 928-4533 to discuss your thoughts and opinions.

Q. All right. To the best of your recollection, and I'm asking it that way -- and let me withdraw it. My understanding, Doctor, is that in your evaluation of medical/legal cases that you do not have a custom or habit of taking notes; is that correct?

A. That is correct.

Q. So when I ask you questions, that's going to be from whatever you remember; is that correct?

A. Yes.

Q. Okay. Did you have a conversation with Ms. Petrello or anyone else associated with her office or Metro Health prior to that letter generally

orienting you to the facts of the case?

A. I do not recall. I imagine that I did, but I don't recall the content of that conversation.

Q. Okay. All right. Subsequent to the time -- well, let me withdraw that. I don't -- you're indicating that this initial correspondence with Ms. Petrello occurred on January 10, 2004. Following your analysis of the records that you indicated, did you draft a preliminary report that you sent to Ms. Petrello relative to your opinions in this matter?

A. I drafted a report after reviewing those records as well as some additional records. The list of the records is outlined in my report.

Q. Okay. I understand that you authored a report on May 16th, and we'll get to that, and all I want to know is prior to the May 16th report 2005, did you author any other reports?

A. No.

Q. Okay. Can I assume, Doctor, that although you did not author another report prior to May 16, 2005, that you would have communicated your preliminary impressions to Ms. Petrello or someone

else not too far after January 10, 2004?

A. Yes.

Q. Okay. Can you recall today what your preliminary impressions regarding this matter were?

A. My recollection is that my preliminary impressions were similar to those outlined in my report. I don't know if you want more detail than that.

Q. I actually do, if you have more detail. Okay. You're saying you had similar opinions, was there information that had not yet been provided to you that you felt you needed to draw the conclusions which you are going to testify to in this case?

A. I don't recall needing any additional information other than those medical records.

Q. Okay.

A. I did receive additional information after that time. That additional information did not substantively change my opinions.

Q. All right. And any additional information that you would have received, Doctor, can I assume that is, first of all, deposition testimony?

A. Yes.

Q. Okay. And whose depositions do you recall reading?

A. I'd have to look at my report for the specific list, if that's all right.

Q. Doctor, this isn't a memory contest. Anytime you need to refer to your charts or the records, that's fine.

A. It will take me a moment to find my report. It's in here somewhere. Okay. Deposition of Greg Lewis -- no, yes. By the time I had written my report I had reviewed the deposition of Greg Lewis, deposition of Kimberly R. McKanders, autopsy record of Sonoma Davis, expert's report prepared by Dr. John Barks, and expert's report prepared by Dr. Mark Perlman.

Q. Okay. Subsequent to writing the report have you received additional depositions and/or reports?

A. Yes.

Q. And can you outline those for me?

A. Yes. It will be just a moment to get them organized here.

Q. No problem.

A. A report prepared by Dr. James

Hinsdale, a report prepared by Dr. George Huggins, a report prepared by Dr. Stephen Devoe, a report prepared by Dr. Floyd Giles, a report prepared by Dr. Kathleen Clem, and depositions of Mr. Norman Davis, Ms. Cheryl Austin, and Dr. Michael Firstenberg.

Q. Okay. Doctor, although I do know that you do not take notes relative to your analysis of material, do you highlight depositions as you read them?

A. I do not.

Q. Okay.

MS. PETRELLO: Donna, do you --

Q. Do you tab pages?

A. No.

MS. PETRELLO: Donna, just one second.

MS. KOLIS: Yes.

MS. PETRELLO: He also last night had Barks' depo, just so that you know.

MS. KOLIS: Okay. Don't hit the table again because I lost the doctor again.

(Brief recess)

BY MS. KOLIS:

Q. If I have taken good notes, the last place we were before we had a little technical

interruption was discussing additional information, and I last learned that last night Dr. Greenberg was able to or did receive the deposition of Dr. John Barks. Is that where we left off?

A. Yes.

Q. Okay. Great. Doctor, have you seen any of the films in this case, the ultrasound films specifically?

A. No. I've only seen the reports.

Q. Okay. Do you believe, Doctor, that you need to see the films to draw any conclusions in this matter?

A. No, I do not.

Q. Okay. Doctor, from reviewing your curriculum vitae and other materials available to me on the internet, it would appear that your specialty is neonatology, correct?

A. That is correct.

Q. All right. And to make sure that we don't take a long time today, I'm not going to go through your educational background, although it is interesting, but suffice it to say you are a Board certified physician, correct?

A. Yes, I am.

Q. You're Board certified in?

A. Neonatology.

Q. Pediatrics -- go ahead.

A. Neonatology and perinatal medicine.

Q. Okay. You received that Board certification in what year?

A. Oh, boy.

MS. PETRELLO: Here's your CV. I'm just handing him his CV.

A. I think it's 1989, but I honestly don't remember. It's been a while and I've recertified twice, the most recently last year.

Q. All right. Doctor, you are licensed to practice medicine in the State of Ohio, correct?

A. Yes, I am.

Q. Do you have an inactive status on any license in any other state?

A. Yes, I do, in Minnesota.

Q. Okay.

A. And just to clarify, I recertified last in neonatology and perinatal medicine in 2003. Time flies.

Q. Okay. And currently at Cincinnati Children's Hospital, first of all, that is the only

place you practice medicine; is that correct?

A. That's not correct. I actually practice medicine at several other hospitals in Cincinnati.

Q. Are those -- okay. Then I did misunderstand. I thought that you spent virtually all of your time at Cincinnati Children's Hospital.

A. No. It's a bit confusing. The division of neonatology provides neonatal care for infants at nine other hospitals besides Cincinnati Children's. We are all Cincinnati Children's employed and privileged and credentialed through Cincinnati Children's as well as those other hospitals. The bulk of my neonatal intensive care time is spent at Cincinnati Children's, but I also see patients at several other hospitals. I'm happy to list those for you, if you need them.

Q. As it regards the time that you spend at other hospitals, which we're just going to briefly get into this, are you -- you're providing neonatal care services there --

A. Yes, I am.

Q. -- at the other hospitals, correct?

A. Yes.

Q. I note that you have some research interests, but essentially my understanding is that, in fact, you spend at least 75 percent of your time in the clinical practice of medicine; is that an accurate statement?

A. Yes, it is.

Q. Okay. Doctor, in reviewing your curriculum vitae I did not discern that there were any particular articles that you have authored that directly dealt with the issues in this case. Do you agree with that statement?

A. I have authored an article since the time that this CV was prepared about prematurity. I don't think it's on this CV. Let me just look.

Q. The CV I have is dated 5/27/05. That may be a print date. I don't know if it's the edit date or not.

A. It's the print date and there is one new article that's now been published regarding prematurity. It was a very brief four-paragraph review of an article on prematurity that appeared in the Journal of Pediatrics 50 years ago, and I wrote a short review about that article for the Journal of Pediatrics, and my review was published in July, I

believe.

Q. July of 2005?

A. Yes.

Q. Okay. If I understood what you were saying, because I'm writing and trying to listen at the same time, the article that you just published in the Journal of Pediatrics in July of 2005 is a four-paragraph review of an article written 50 years ago?

A. Yes.

Q. Okay.

A. It's --

Q. Is it -- go ahead.

A. It's for a series that appears in the Journal of Pediatrics Entitled 50 Years Ago In The Journal.

Q. Oh, okay. And did you update it and say how things have changed? What was the essence of this article on prematurity that you wrote?

A. The essence was as you described, an update about what's changed and what hasn't changed in the -- regarding premature -- prematurity and premature infants over the past 50 years.

Q. Did that article in any way address

the improvements in morbidity and mortality for premature births in the past five decades?

A. It alluded to improvements. It was a very short article.

Q. Okay. All right. Getting a little bit closer to what you are probably anxious to talk to, I have read your report, Doctor, and I would like to, first of all, ask you, have you been asked to render opinions relative to the standards of care of any of the physicians involved in this case?

A. Yes.

Q. Okay. What physicians' conduct will you be addressing?

A. I'll be specifically addressing the conduct of the neonatologists and the conduct of the obstetricians, and on a limited basis the conduct of the emergency room physicians.

Q. All right. Let's go through each of those for a second. Doctor, do you have reason to believe, based upon the reports that you have read that were submitted by my experts, that we ever had any criticisms about the neonatologists at Metro Health Medical Center?

A. I don't perceive any criticisms of the

neonatologists.

Q. Okay. I want to make sure you didn't think that I had -- I will state for the record that this is not a basis of our criticism of Metro Health. What do you perceive to be the basis of our criticism against the obstetrical department at Metro Health?

A. My perception is that your concerns or your clients' concerns relate to the timing of delivery.

Q. Okay. Doctor, do you agree with me that once Cheryl Austin arrived at the obstetrical unit at Metro Health she was quickly and appropriately delivered?

A. Yes, I believe she was delivered in a timely fashion.

Q. Okay. So given that you and I both now know that I don't have any criticisms with what occurred on the floor, what is your understanding about my criticisms relative to obstetrics prior to that time?

A. My understanding is that the criticisms or your criticisms relate to the timeliness of delivery, that delivery should have occurred sooner.

Q. Okay. All right. And that's fair. Doctor, in what manner do you feel qualified to testify on behalf of the obstetrical department at Metro relative to the timing of delivery?

A. As a neonatologist I work directly with obstetricians and maternal fetal medicine specialists to determine or ascertain appropriate timing for delivery.

Q. All right. Let me -- this is -- I don't mean for the question to be esoteric, but just in terms of establishing the foundation, and perhaps it will help the jury in this trial, I gather, Doctor, that when you tell me that you help assist the obstetricians relative to the timing of the delivery, that is because as a neonatologist perhaps you're in a better position to assess fetal well-being than an obstetrician is?

A. In general I would agree with what you've said. I think I'm in a different position to assess fetal well-being. My perspective is from that of the fetus. However, I'm obviously very aware of the maternal issues that the obstetrician has to deal with as well.

Q. Do you consider yourself to be the

patient advocate for the fetus when you're called in that kind of circumstance?

A. That's one way of putting it, yes.

Q. Okay. Is there another way of putting it?

A. Well, I'm not -- I'm not advocating solely for the fetus. I'm very aware of the fact that the fetus is connected to the mother and that the fetus' well-being is directly connected, if you will, with the mother's well-being, but in that context I'm focusing on the status of the fetus and assisting the obstetrician regarding timing of delivery with respect to my perspective.

Q. Timing of delivery, when you use that phrase, does that include, Doctor, the decision to deliver an operative delivery in a situation where you feel that a fetus is at risk or -- go ahead.

A. No, I don't ever make a decision about delivery, either operative or vaginal delivery. My role is that of an advisor to the obstetrician and sometimes to the family as well.

Q. Okay. Thank you very much for that answer. And you said to a limited basis you would be addressing standards of care issues for emergency

room doctors; is that correct?

A. Yes.

Q. Okay. Can I ask, Doctor, at Cincinnati Children's Hospital and the associated other hospitals where you provide services, are you on occasion called to the emergency room to be an advisor in the situation of the arrival of a pregnant woman?

A. Yes. It occurs very infrequently, but I have been asked to participate in those evaluations.

Q. Okay. And the reason I ask that, the next question is going to be, from your own perspective can you explain to me why you feel that you are qualified to render standard of care opinions relative to the conduct of the emergency room physicians?

A. Only in my activities in the emergency room. In other words, when I'm called to the emergency room it is usually because a delivery is imminent or felt to be imminent and there -- they want me to be present because there may be a baby that requires resuscitation.

MS. PETRELLO: And, Donna, just so

that you're clear, we have -- we're not going to be asking him whether or not anybody -- any of the emergency room physicians, whether their care comported with the standard of care. We have other experts for that, so that's clearly not something that we're going to be addressing with Dr. Greenberg.

Q. Okay. I wanted to be certain about that because, Doctor, I'm sort of testifying on the record, but I'm seeking clarification. A fair number of depositions were taken of Metro Health employees, and as I reviewed your report it struck me that the two depositions of Metro Health Medical Center employees that you were given were that of Dr. Greg Lewis, who is an emergency room physician, and Dr. McKanders, who is an obstetrician, so that's why I wanted to see if I had missed something.

But going back to where you were, if I understand your testimony, and I would accept it to be at face value, there are situations where people arrive at Cincinnati Children's Hospital where other physicians in the emergency room make the determination that delivery may be imminent and a baby may be in trouble and they do call for you input

and possible resuscitation; am I stating that fairly?

MS. PETRELLO: Objection. Go ahead.

A. Yes, with the emphasis on potential for resuscitation.

Q. Okay.

A. That's why they want me there.

Q. Okay. I'm glad to limit it to that. If they don't call you down to the emergency room in a advisory capacity relative to someone's presentation for delivery, that's fine. Because I would assume since you are a highly-skilled neonatologist they would want you there for resuscitation, so I can accept that. All right. You are, of course, going to be offering opinions on causation relative to the cause of Sonoma Davis's death; is that correct?

A. Yes.

Q. Okay. Let's make this sort of general, first of all, is Cincinnati Children's Hospital considered a level one trauma center?

A. Yes.

Q. Okay. Given that it's a level one trauma center, Doctor, do you participate in, I'm going to call them action plans? That may not be a

word that you're familiar with, but the formulation of plans as to how to manage a maternal fetal trauma in your emergency room department.

A. No.

Q. Are you aware of the committee at your hospital that does perform that action plan?

A. I'm only aware of the committee in a very general sense. And one point I should make for clarification, Cincinnati children's being a Children's Hospital rarely, rarely has pregnant girls or women admitted or coming through the emergency room even, so it would be a very unusual circumstance.

Q. All right. And that's part of the question I'm asking. You are a level one trauma center for children, but on occasion, at least this must be partially the basis why you were asked to be an expert, you must see pregnant women in the emergency room; is that a fair statement?

A. Actually not at Cincinnati Children's, but at some of those other hospitals that I cover I will on occasion see pregnant women in the emergency department.

Q. Can you -- you know, I didn't afford

you the opportunity to tell me what those other facilities were, but now that it's become germane, could you indicate for me what facilities it is where you have privileges that you do see pregnant women in the emergency room.

A. Over the past ten years the hospitals include Bethesda North Hospital, Mercy Fairfield Hospital, Mercy Anderson Hospital, Mercy Franciscan Mount Airy Hospital, and Fort Hamilton Hospital. I do see patients at other hospitals in Cincinnati, including University Hospital and the Christ Hospital, but I don't recall ever being in the emergency department at those two hospitals.

Q. Okay. Thank you very much for that answer. Of the hospitals that you listed, are any of those considered a level one trauma center?

A. I do not know.

Q. Without looking at your curriculum vitae, which would make it easy, but I'm not doing it, are you certified in advanced trauma life support?

A. No, I'm not.

Q. Are you certified in ACLS, advanced cardiac life support?

A. No.

Q. All right. Doctor, would you agree with me that Sonoma Davis was born on, I always get it wrong, May 12, 2003 because there was a placental abruption?

A. Yes, I think that's likely to be the reason she delivered.

Q. Doctor, this is my fault once again for not being there in person and being a little more organized, I'm going to ask -- any questions that I ask you today of a medical nature, I'm going to be asking you those questions to a reasonable degree of medical probability. I'm assuming you understand what that means, more likely than not.

A. Yes.

Q. Is that your understanding? That way I won't have to keep asking you is this opinion to a reasonable degree of medical probability, which gets rather redundant. Would you agree with me, Doctor, from a totality of the medical information that is available to us, both through the Metro Health medical records and those at Rainbow Babies and Children and then, unfortunately, the post-mortem report of University Hospitals of Cleveland, that but

for the abruption that occurred on May 12, 2003 we would have no reason to believe that this pregnancy would not have continued in a normal fashion?

A. Based on the information that I have I would have expected this pregnancy to continue. I do note that Ms. Austin had two other pre-term infants which puts her at a somewhat higher risk of having another premature infant, but I have no reason to believe that she would not have been able to carry the pregnancy for many weeks following.

Q. All right. And just to carry it to its logical conclusion so we don't have issues at trial that we should be dealing with, there was no evidence whatsoever in the chart of any congenital abnormalities, would you agree with that?

A. I understand the infant had a cleft palate. Other than that there were no congenital abnormalities.

Q. And I do stand corrected, I should have said no congenital abnormalities that would have been life-threatening or had with them a high potential for mortality.

A. Yes, I agree with that.

Q. Okay. Doctor, from your review of the

medical charts at Metro Health Medical Center for May 12, 2003, can you give me your best assessment of how much time Cheryl Austin spent in the emergency department before she arrived at labor and delivery?

A. I'd have to look at the record to be precise.

Q. You may do so. It's okay.

A. Is it this one?

MS. PETRELLO: No.

A. This one. I'm looking to see when she arrived. I know it was sometime after five. It looks like she arrives at 5:00 p.m. approximately. It looks like 1701 here or 1710. It's either 1701 or 1710. On the trauma flow sheet there are two different times, and I'm looking -- this is where I believe when she -- this is delivery room three. Sorry. I'm just looking here.

Q. It's okay.

A. It appears to me that she arrives in OB at 1927.

Q. Having arrived somewhere around 1710; is that right?

A. Arrived in the emergency room at 1710 and in the obstetrics area at 1927, so about two

hours and 15 minutes.

Q. And delivered at what time?

A. 1948.

Q. Okay. So that you and I are clear then, from time of arrival at ED to time of delivery is approximately two hours and 30 minutes, 38 minutes, about two and a half hours?

A. I'm sorry, you said the time of delivery?

Q. Yes. Yeah. Time of delivery.

A. Yes.

Q. Just you and I speaking, if you don't mind, we can call it two hours and 30 minutes for purposes of our medical/legal conversation today.

A. That's fine.

Q. Doctor, can you please indicate for me the condition of Sonoma Davis, the child, between 1710 and 1927?

A. You mean 1710?

Q. Exactly. We'll stick with one nomenclature, I will say 1710 and 1927, can you tell me from the records what the condition of this baby was?

A. It's very difficult to tell.

Q. Okay. Tell me in simple medical terms why it's difficult for you as a neonatologist to tell what the condition of this child was between 1710 and 1927.

A. There's very little monitoring information, and actually very little intermittent auscultation as well.

Q. Suffice it so say, Doctor, you're recognizing that because there isn't monitoring that which you have to testify today to is going to be based upon working a timeline backwards based upon information available at the time of birth, would you agree with that?

A. I would agree and add that it was from the time of birth and beyond the infant's hospital course as well.

Q. Okay. This question is not in order, but I'm going to ask it anyway, Doctor, do you agree that Sonoma Davis ultimately died because she had no gag reflex?

A. No, I don't think that was the sole cause of death.

Q. All right. Having said that, let me break it out a little bit differently then, obviously

we'll go back and talk about the day of May 12th and a few days afterwards, do you agree since the way I heard your answer that the fact that Sonoma Davis did not have a gag reflex was a contributing cause to her death?

A. Yes, it contributed to her death.

Q. Okay. And in what way did it contribute to her death?

A. It caused her to have chronic aspiration.

Q. Which ultimately then caused her to experience what?

A. Pneumonia, aspiration pneumonia.

Q. Getting, I guess, right to the heart of the issue, Doctor, to a reasonable degree of medical probability, based upon your specialty, what caused this child not to have a gag reflex?

A. Her obstructive hydrocephalus and periventricular leukomalacia.

Q. The cause of that PVL was an anoxic incident prior to birth?

A. We don't understand what causes PVL. I have many patients, unfortunately, who have PVL for whom we can never identify an anoxic incident, so

it's difficult for me to arrive at that conclusion. I certainly wouldn't reach that conclusion to a degree of reasonable certainty.

Q. Do you agree that this child had an anoxic event which occurred at or about the time of birth?

A. The infant had evidence of metabolic acidosis. I, you know, anoxia has to be measured and we have no way of measuring that, and the metabolic acidosis is also a bit confusing because of the infant's Apgar scores, but I believe it is reasonable to conclude that the infant had a significant metabolic acidosis, which was related either to a lack of oxygen or low blood flow.

Q. I'm sorry, I'm writing, if you don't mind. In fact, once again, we're jumping around, having had the opportunity, Doctor, to review testimony that you've given in other cases, we are both -- well, I -- to the best of my ability to read this medical chart and record numbers, it would appear that her arterial cord gas at the time of birth was 6.677 with a minus 29.5 and her -- her cord then was 6.684. I didn't see those numbers in your report. Is that your recollection that those were

the approximate cord gas numbers?

A. Yes.

Q. And those represent a rather severe metabolic acidosis? Maybe I shouldn't say severe. Go ahead.

A. Those cord gas values do clearly represent a metabolic acidosis.

Q. Okay. And you indicated that the cause of the metabolic acidosis was lack of 0_2 and/or low blood flow?

A. Yes.

Q. Okay. I'm trying to, the best I can, to listen and write. What would have caused the lack of 0_2 in this baby based upon all the evidence that you have available to you?

A. The best evidence is that it was due to the placental abruption.

Q. What about the lack of blood flow?

A. The placental abruption.

Q. Okay. Just so we're speaking in each other's language, I want to make sure I won't be surprised and hear there was some other cause. Doctor, do you have an opinion based upon the information available to you as to whether or not

Sonoma could have had a better outcome relative to her neurological status had she been delivered sooner than what we're calling the approximate two and a half hours after arrival to Metro Health Medical Center?

A. I do not believe it would have made a significant difference in her outcome.

Q. Okay. You used the word significant, so let's deal with that. Can I assume that we'll be able to maybe agree that you think it could have made some difference in her outcome had she been delivered sooner?

A. It's impossible to determine. I mean in a hypothetical sense any infant delivered at that gestational age is at high risk to encounter all of the problems that Sonoma Davis encountered, so the timing of delivery makes it hard to -- the timing of delivery in this particular situation for me does not change my opinion about the outcome.

Q. All right. Let me ask some generalized, I guess, other questions. Just to cover the bases, I don't know if you'll agree with this out of the box or not, we might have to work it through, based upon the recovery that I saw from resuscitation

and blood gases, and I think we've covered it, but to be clear, would you agree with me that Sonoma Davis was not experiencing ongoing anoxic insults prior to the time of this placental abruption?

A. I have no way of knowing.

Q. Okay. Doctor, what is the purpose of fetal monitoring?

A. That's a very good question. Fetal monitoring actually hasn't been shown to be particularly useful with respect to outcome and preventing problems like cerebral palsy and other neurologic deficiencies. Probably the best use of fetal monitoring is to identify profound changes in fetal well-being that necessitate an urgent delivery.

Q. Profound changes being -- well, I think I can guess what they are because I just read the James Saravac deposition, but why don't you list them for me.

A. Sure. Persistent fetal bradycardia or low heart rate.

Q. Right.

A. Severe late, persistent late decelerations, absent variability. That's all I'm remembering right now.

Q. Okay. Well, I think that's covered in what you just recently testified to.

A. Okay.

Q. And that's -- in this particular instance, we're going to shift gears again, Cheryl Austin presented to the emergency department, and see if you agree with me, as the mother of a 26-year-old (sic) viable fetus who potentially had suffered a placental abruption? Do you agree with that?

A. It's certainly one of a large list of problems that Ms. Austin and the baby could have had, but it's on that list.

Q. And it's on that list, Doctor, because she sustained a high speed MVA where there was a collision between the steering wheel and her abdomen, would you agree that's one of the reasons it's on the list?

A. Yes.

Q. Okay. Would you also agree one of the reasons that placental abruption was on the list is because the emergency personnel report, the ambulance transport immediately reported a diffuse abdominal pain, would that also have put it on the list?

A. Amongst many other things, yes.

Q. Okay. The fact that she was not bleeding vaginally, either in the ambulance or at her presentation to the emergency room department, that is not a fact that would exclude it from being within the differential, do you agree with that?

A. It makes it less likely, but it does not exclude it from the differential.

Q. Knowing that there is a potential abrupted placenta in a 26-week-old viable pregnancy, would you agree that the standard of care required that, I'm going to say someone assess fetal well-being to the extent that they could know whether or not any of these profound changes were occurring with this baby?

MS. PETRELLO: Objection.

A. I would actually say that the most important thing to do is to establish the well-being of the mother in a situation like this. For the fetus that's the most important intervention. And until the mother's well-being is well-established in a very real sense, the well-being of the fetus is moot.

Q. All right. Well, let's deal directly with the facts of this case and not hypothetically.

A. Uh-huh.

Q. You've already acknowledged that you are not ATLS certified; is that correct?

A. That's correct.

Q. So you don't exactly have any information on what the American College of Surgeons and Trauma Surgeons say about the order of assessment; is that a fair statement?

A. Yes, it is.

Q. Okay. However, in this particular instance, can you point out to me, Doctor, any time during the interactions beginning with when she first arrives, once her ABC's are clear, that this child could not have simultaneously been monitored while mother's evaluations were ongoing?

A. Perhaps you can clarify your question. Are you asking me whether it would be physically possible to monitor?

Q. Absolutely. That's what I'm -- from what -- just from the chart itself and the sequence of timing of events, tell me where -- well, excluding when she was in the CAT scan, but from when mom first presented, wasn't it possible to simultaneously have somebody who was capable of doing fetal monitoring

and monitor the mom simultaneously while things like blood pressure are being taken, resuscitation of fluids for mom?

A. I have no way of knowing for sure because I am never called to the emergency room to participate in an evaluation on that basis. The -- but, you know, the mechanics of fetal monitoring are such that it may have been possible, but I'm really not qualified to say because it does require placing monitors and so on that they may not have been able to do because they were worried about her C-spine status or other things that I'm really not qualified to address.

Q. All right. So that we're clear about that then, Doctor, since you just testified to that, at the trial of this lawsuit you're not going to say that it was appropriate for them not to have monitored the mother with equipment in the emergency room?

A. Boy, I don't follow what you just said. I'm sorry. If you could just -- it sounded like a double negative that I couldn't follow.

Q. It could have been, I'm famous for the double negative. I'm not trying to do that. In

other words, when I asked you the questions couldn't they have done simultaneous fetal monitoring, I thought that your answer was that you couldn't answer that question because that's not what you do. So what I'm trying to elicit is now that you've said that, at trial you're not going to say that Dr. Lewis and/or the trauma staff met with the standard of care in not monitoring the mom in the emergency room.

MS. PETRELLO: Right, Donna, we're not going to ask him that.

A. Right. I'm not going to render an opinion about whether they should or should not have monitored in the emergency room because I never, never in my career have been asked to participate in that aspect of an evaluation in the emergency room.

Q. Have you ever, Doctor, been asked to -- you probably have covered this, but I just want to be very specific, have you ever been asked to come to an emergency room to evaluate a patient prior to the time they know they're going to deliver her, but when there is a suspected placental abruption?

A. No.

Q. Okay. Once Sonoma Davis and her mother arrived at labor and delivery, did you find

any evidence of persistent fetal bradycardia on the strips that are available, the limited strips, prior to delivery?

A. I'd have to look at the strips right now just to be clear.

Q. That's fine.

A. Yeah, the strips are really inconclusive. I just wanted to make sure I remembered. I have two pages of monitoring and actually the only markings on the monitors are a few little dots of somebody's heart rate between 80 and 90, I don't know if it's the mother or baby, and it's certainly not enough information to ascertain one way or another whether there is significant fetal bradycardia or fetal distress. I can't render an opinion based on the monitoring strips.

Q. Based on your reading of Dr. McKanders' deposition or the medical record itself, what was the basis for Dr. McKanders to conclude that an emergency C-section was warranted?

A. It's my understanding it was persistent bradycardia, and I don't remember the exact numbers that they described. 80 to 90, I believe, but let me look.

Q. That's okay.

A. I'm sorry, 60 to 70.

Q. Okay.

A. Yeah.

Q. So that's my understanding, all right. And, Doctor, just so you and i are at least on the same page we can be on, you would agree with me that mom and baby arrived on the floor at 1927, we both agree that she was delivered at approximately 1948, that's about 21 minutes, correct?

A. Yes.

Q. And you have no reason to believe, based upon the reputation of Metro Health Medical Center, that if there had been an emergency C-section called at any time prior they couldn't have done it that expeditiously, do you?

A. That's the standard of care, is to do a delivery within 30 minutes, and they met that standard, and I would expect that they would do that under any other circumstances.

Q. Okay. Doctor, based upon your evaluation and analysis of the delivery records and any information that was available about them, if that's the basis that it would be, do you have an

opinion as to whether or not Cheryl Austin had a complete abruption at the time of the collision or a partial abruption?

A. Based on my review of the records I believe that it was not a complete abruption.

Q. Do you believe that it was a partial and it progressed?

A. I have no way of telling whether it progressed. But I agree that it was partial.

Q. Okay. All right. When there is a partial abruption of the placenta, could you just, from a neonatologist's perspective, sort of outline for me what begins to happen to the infant at the time of abruption?

A. It's extremely variable. There are many infants who are found to have a partial abruption at the time of delivery and have absolutely no problems at all. There are other infants who are profoundly affected by a partial abruption and are substantially more depressed than even this infant. So it's a variable phenomenon and it's difficult, frankly, it's impossible to look at an abruption and correlate it with the status of the infant.

Q. Okay. Once again, since it's

impossible to do that, that's why it's important to monitor a child in a situation where you believe abruption may have occurred to see if there are effects that have occurred for that particular baby, would you agree?

MS. PETRELLO: Objection.

A. It depends on the circumstances. I think that anytime a woman presents in labor, presents with complaints of one sort or another, that may suggest that she is in labor, that monitoring is part of that care, but I'm not specifically relating that to a trauma situation.

Q. Doctor, do you know either one of my experts, Dr. Barks or Dr. Perlman, either personally or by reputation?

A. I do not.

MS. PETRELLO: Donna, are you hearing that? I have no idea but they're building something out there. Can you hear that?

MS. KOLIS: It's a good sign for Cincinnati's economy, it must be thriving if they're doing construction.

MS. PETRELLO: I hope it's not interfering with you.

MS. KOLIS: It's not interfering.

(Discussion off the record)

BY MS. KOLIS:

Q. All right. Doctor, at the time of birth, let's talk about Sonoma right after her birth. Would you agree with me that the first head ultrasound did not indicate an intraventricular hemorrhage?

A. Yes. Are you speaking to the ultrasound on, I think it was 5/13?

Q. Yes.

A. Yeah, the ultrasound on 5/13 at 10:32 p.m. does not show evidence of an intraventricular hemorrhage.

Q. Okay. Based upon your summarization of this medical chart, Sonoma developed an intraventricular hemorrhage on or about what date?

A. I believe, I'd have to look, on a follow-up ultrasound.

Q. I think it's day of life three, but I don't want to misstate that in the record.

A. 5/15, so that would be day of life three.

Q. Okay. And in her particular

circumstances, do you have an opinion as to the cause of her intraventricular hemorrhage?

A. It's associated with her extreme prematurity. The causes of intraventricular hemorrhage, the specific mechanisms are still not completely understood, but it's clearly, in my opinion, related to her prematurity.

Q. The coagulopathy Sonoma had was related to what?

A. The coagulopathy was related to her metabolic acidosis and prematurity.

Q. So it was a dual cause for that, would you agree --

A. Yes.

Q. -- or even --

A. Well --

Q. Go ahead. I'm interrupting you and I didn't mean to. I'll let you finish your answer.

A. That's all right. The difficulty in terms of sorting out what's due to metabolic acidosis and what's due to prematurity has to do with the fact that there's no such thing as a normal planned delivery at 26 weeks' gestation, so my opinion is based upon my experience with other infants delivered

at 26 weeks' gestation. Many of those infants have metabolic acidosis because they have immature kidneys and respiratory difficulties that prevent their ability to compensate for the metabolic acidosis.

Q. Relative to those babies and, once again, those babies is pretty general, but the ones that you just talked about with immature kidneys and respiratory difficulties, do you subcategorize those children with metabolic acidosis into groups where the mom went into spontaneous labor and labored for a little bit or were they all emergency C-sections? Is there a way for me to distinguish the patient population that you're discussing?

A. No, there's not. The complications or sequelae, to use the medical term, of prematurity occur on a frustratingly random fashion and are not associated with modes of delivery or causes of pre-term delivery.

Q. Okay. Doctor, so that I have something on the record for myself, you deal with 26-week-old infants on a regular basis, correct?

A. Yes, ma'am.

Q. I'm not -- how many times a year do you care for a child who is born at or about the

26-week gestational marker?

A. I'd say five to ten patients a year. It varies quite a bit. Sometimes it seems like it's 15 or 20, sometimes less.

Q. Okay. So some years you're pretty stressed and some years hopefully not as stressed. But relative to your -- forget the medical literature, relative to your own personal experience, with your five to ten or your 15 a year, do all of these children have poor outcomes?

MS. PETRELLO: Objection.

A. I'd have to ask if you could be more specific about outcomes. Are you talking about at the time of discharge from the NICU or five years of age or two years of age? Just to be more specific if you could --

Q. Okay. I guess we can have that conversation. As you may be aware -- did you have an opportunity to read Dr. Barks' deposition last night?

A. Yes, I read it quickly, but I did read it last night.

Q. Okay. Before I get into anything relative to outcomes, did you find any of his opinions to be disingenuous in any way from your

perspective as a physician?

A. If you mean dishonest, by that --

Q. Yes.

A. -- no.

Q. That's correct.

A. No.

Q. All right. You may from your quick reading that Ms. Petrello did question Dr. Barks about the effects of prematurity. For the record, I think we can agree that being born at 26 weeks is a challenge, that there are problems associated with birth at that age, so what I want to ask you about is about outcomes.

Doctor, based upon where the state of medicine was for you in the spring of 2003, I just generally want to know if you have statistical categories of how many of these children born just strictly at 26 weeks with, and let's throw in the factor of Sonoma's weight because she was just a little over a thousand grams; is that right? I think 953, 957, somewhere in there.

MS. PETRELLO: I think it was 940.

Q. Just based on prematurity, were you --

A. Your question relates to survival at

26 weeks or?

Q. Morbidity and mortality.

A. Okay. In terms of mortality, it's difficult to be specific on a week-by-week basis, but in general with infants under a thousand grams in Cincinnati the mortality risk is between 25 and 30 percent. In other words, between 70 and 75 percent of those infants survive.

Q. Okay.

A. That's a general under a thousand gram category.

Q. Okay.

A. And in terms of morbidity there are various risks for the morbidities associated with prematurity, those risks range from intraventricular hemorrhage, at that gestational age I would expect between somewhere between 15 and 20 percent of those to have intraventricular hemorrhage. I would expect a somewhat larger percentage, probably 30 to 40 percent of those infants to have some degree of retinopathy of prematurity stage two or beyond.

I would expect somewhere between ten and 20 percent of those infants to have a significant patent ductus arteriosis. I wish I could remember

our chronic lung disease rates for those infants. I would estimate that it's around 40 to 50 percent, defined as having an oxygen requirement at 36 weeks post-conceptional age. And then the risk of respiratory distress syndrome at that age is very high, at least 90 percent, and I think in real terms closer to a hundred percent.

Q. Okay.

A. Now, many of those infants have more than one of those problems, and actually very few, if any, are morbidity free of the survivors, meaning that it is very unusual for a 26-week gestation infant to escape all of those complications. Some have many, some have just one. They -- almost all of them have at least one.

Q. Okay. I just have a really quick question to ask you, relative to your review, and I know that you reviewed all of the available records on Sonoma, at 36 weeks post gestation age did she have an 0_2 requirement?

A. I would have to look at the record. I'm happy to do that.

Q. Go ahead. That's fine.

MS. PETRELLO: Donna, I think you said

36 weeks. I'm assuming you meant 26 weeks.

MS. KOLIS: He said 36 weeks in his assessment of morbidities and co-morbidities associated with prematurity and when he was talking about the establishment of a ventricular and respiratory diagnosis was if the child was still 0_2 dependent 36 weeks post-gestational age.

MS. PETRELLO: I'm sorry.

MS. KOLIS: That's okay. You haven't had enough coffee this morning.

A. As I'm looking at the record here what I recall is that she went home requiring oxygen, but I don't remember for sure, so let me just look here.

MS. PETRELLO: Those are Metro's records. We don't have University's.

A. But it looks like, using the definition of an oxygen requirement at 36 weeks post-conceptual age she is documented to be in room air on July 1st, so by that definition she was free of bronchopulmonary dysplasia or neonatal chronic lung disease. However, in the autopsy there's clear evidence of bronchopulmonary dysplasia.

Q. Okay. All right. Going back to where

we were a while ago, I have to go back to my notes, I want you, Doctor, do for me to the best of your ability to state for me what you are going to testify to the jury what the cause of death was for Sonoma Davis.

A. The cause of death was complications of prematurity, including severe obstructive hydrocephalus, bronchopulmonary dysplasia, chronic aspiration secondary to gastroesophageal reflux, feeding problems, and poor gag reflex.

Q. When you say poor gag reflex, did she have a gag reflex at all, Doctor, that you could discern from --

A. In the notes, the progress notes, she is documented to have no gag reflex. I find it hard to believe that she could have been cared for at home with absolutely no ability to swallow. I believe she had a little bit, but obviously required nursing care and suctioning and support because of her, what I would call, poor gag reflex.

Q. So your point of disagreement then with Dr. Barks once again, to be fair, I know that you just read it last night, do you understand what Dr. Barks testified was his opinion as to cause of

death of Sonoma?

A. I believe his opinion was that certain findings on the neuropathological examination were associated with anoxia rather than with complications of obstructive hydrocephalus and that his opinion is based on those -- those findings, if you will.

Q. Okay. You would -- I don't know if you would agree with this, Doctor, based upon the blood gases at time of birth and any other associated factors, I think you've already agreed that Sonoma in all probability had an anoxic event just prior to the time of birth?

A. I believe that she had some loss of -- some oxygen levels that were lower than normal. I do not agree that it was an anoxic event, and my disagreement is based upon the Apgar scores at the time of delivery, which are surprisingly high given the degree of metabolic acidosis documented in the cord gases.

Q. She -- okay. Those numbers corrected relatively well with resuscitation, would you agree with that?

A. Are you speaking of the Apgar scores or the metabolic acidosis.

Q. No, yeah, not the Apgar scores. The metabolic acidosis.

A. I recall that she had a persistent metabolic acidosis for several days after --

Q. Right.

A. -- after admission, so I guess I would disagree with the statement that they corrected well.

Q. What would be your definition of a metabolic acidosis that corrected well?

A. One that responded to treatment within a few hours with subsequent blood gases being in a normal range with a base axis of better than minus 4.

Q. Okay. Doctor, do you disagree with Dr. Barks that Sonoma Davis sustained a brain stem injury due to an anoxic event?

A. I disagree with the last part of that statement, that it was due to an anoxic event.

Q. Do you believe that Sonoma had a brain stem injury?

A. I believe that her brain stem did not work properly and infer from that that it was injured in some way.

Q. Doctor, do you have an opinion which you'll be rendering at trial as to the cause of the

malfunctioning of her brain stem since you're not calling it an injury?

A. I believe that it was due to obstructive hydrocephalus and due to episodes of hypo tension that occurred during her hospitalization, both during the time immediately after delivery as well as the period after her abductus ligation.

Q. What was the cause of the hypotension immediately following her delivery?

A. It was likely related to her prematurity. I don't have a specific explanation for it other than that. Many pre-term infants have hypotension following delivery. It may have been related to loss of blood volume, although her hematocrits don't specifically reflect a profound blood loss.

Q. Okay. All right. Let's try to quickly summarize, if we can, and I don't want to misstate anything, I completely missed an area. Doctor, are you -- I think that Colleen made it clear after you and I explored the facts of the case that you're not going to be rendering testimony about the standard of care in the emergency room, or did I misunderstand that?

A. The only issue that I would have an opinion about in the emergency room is the importance of establishing maternal well-being in principle, that my experience in resuscitating infants whose mothers have been involved in a severe trauma, is that if the mother is profoundly hypotensive at the time of delivery or in some other way indisposed with unstable vital signs that that is bad for the fetus. That is the only concept, if you will, that I would have an opinion about in the context of the emergency room course for mother and fetus.

MS. PETRELLO: And, Donna, just again for clarification, we're not really going to be asking him questions relative to the care that transpired in the emergency room and whether or not that, you know, complied with the standard of care.

MS. KOLIS: Okay. I don't want to be confused. I mean obviously Dr. Greenberg is highly qualified to speak to causation and I didn't have any objection with that. I was just curious because I didn't see any specific things that he could have addressed.

MS. PETRELLO: We have other experts.

BY MS. KOLIS:

Q. You're not going to discuss about standards of care in a generalized sense, and that generalized sense is not even applicable to this case; is that right? In other words, was this mother unstable?

A. I have no opinion about that.

Q. Fine. Okay. So then I think that what you and I have done is we have covered all of causation opinions, I think you gave me short and concise answers that I understand, so I only have a couple of other questions. Doctor, do you belong to any doctors organizations that are actively advocating for tort reform in the State of Ohio?

A. No. I didn't know there were any.

Q. Oh, there are.

A. Oh, okay.

MS. PETRELLO: That's an interesting question. I haven't heard that one before.

A. Oh, actually -- are you referring to like the Ohio Medical Association? I'm not a member of the Ohio Medical Association, but I do -- I get letters from them every so often about tort reform, but, no, I'm not a member of any organization.

Q. All right. And I'm not asking you this question to harass you in any way, but, Doctor, have you ever been sued for professional liability?

A. No, I have not.

Q. Okay.

MS. PETRELLO: Objection.

Q. I didn't find one on the index, but computers are only as good as their operators and sometimes the information is not included. And one final bias question, I suppose, Doctor, who covers your professional liability insurance? Who are you insured by?

MS. PETRELLO: Just note an objection.

A. We are insured at Children's Hospital. We are self-insured.

Q. Okay.

A. And the name of the insurance company that, I guess, Children's Hospital owns is called River City Insurance.

Q. So it's your own internal insurance?

A. It is self -- self coverage.

Q. Okay. Doctor, do you believe that I have fairly and adequately covered all of the opinions which you are going to be offering at the

trial of this lawsuit?

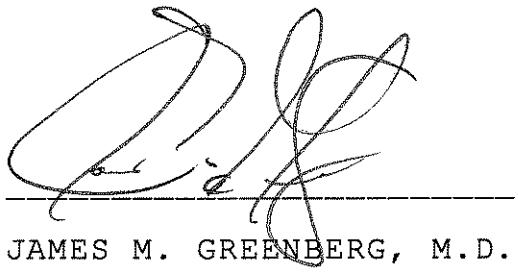
A. Yes, I do.

MS. KOLIS: Okay. Having said that, thank you very much. Don't forget to prepare a bill. And I assume he will read his deposition.

MS. PETRELLO: Yes, he will.

MS. KOLIS: Okay. I will waive the seven days, I think.

(Deposition concluded at 10:00 a.m.)



JAMES M. GREENBERG, M.D.

CERTIFICATE

STATE OF OHIO :

: SS

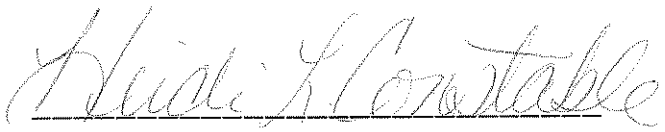
COUNTY OF HAMILTON :

I, Heidi L. Constable, RPR, RMR, the undersigned, a duly qualified and commissioned Notary Public within and for the State of Ohio, do hereby certify that before the giving of his aforesaid deposition, the said JAMES M. GREENBERG, M.D. was by me first duly sworn to tell the truth; that the foregoing is a deposition given at said time and place by the said JAMES M. GREENBERG, M.D.; that said deposition was taken in all respects pursuant to agreement of counsel as to the time and place; that said deposition was taken by me in stenotypy and transcribed by computer-aided transcription under my supervision; and that examination and signature to the transcribed deposition is not waived.

I further certify that I am not a relative, employee of, or attorney for any of the parties in the above-captioned action; I am not a relative or employee of an attorney of any of the parties in the above-captioned action; I am not financially interested in the action; I am not, nor is the court

reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28(D).

IN WITNESS WHEREOF, I hereunto set my hand and official seal of office at Cincinnati, Ohio, this 18th day of October, 2005.



My commission expires:
January 5, 2010

Heidi L. Constable, RPR, RMR
Notary Public/State of Ohio

CORRECTIONS TO TRANSCRIPT

CIN-TEL CORPORATION
813 Broadway, Suite 200
Cincinnati, Ohio 45202
(513) 621-7723

CASE NUMBER: 538,701

Case Caption: CHERYL AUSTIN ADX, ESTATE OF SONOMA DAVIS V. METROHEALTH MED CTR ET AL

Deponent: James M. Greenberg M.D. Date: Oct. 10, 2005

Page#	Line#:	
1	6	"Cause" → case
36	8	"I," → As
39	17	"Saravac" → Cerovac