

CHE STATE of OHIO,  
COUNTY of CUYAHOGA.

IN THE COURT OF COMMON PLEAS

MONICA DIXON, et cetera, -  
                    plaintiffs, :  
-  
vs. .         Case No., 324550  
.         UNIVERSITY HOSPITALS  
OF CLEVELAND, et al., -  
                    defendants. .

Deposition of JOHN GRIFFITH, M.D., a  
witness herein, called by the plaintiffs for the  
purpose of cross-examination pursuant to the Ohio  
Rules of Civil Procedure, taken before Kris A.  
Adorjan, Notary Public within and for the State of  
Ohio, at University Hospitals, 11100 Euclid Avenue,  
Cleveland, Ohio, on WEDNESDAY, JUNE 17TH, 1998,  
commencing at 2:04 p.m., pursuant to agreement of  
counsel.



FLOWERS & VERSAGI

## COURT REPORTERS

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23     Also present:

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25     Matt Albers

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I N D E X

WITNESS:

JOHN GRIFFITH, M.D.

PAGE

Cross-examination by Mr. Cullers

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NO EXHIBITS MARKED

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(FOR COMPLETE INDEX, SEE APPENDIX)

(IF ASCII DISK ORDERED, SEE BACK COVER)

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JOHN GRIFFITH, M.D.

of lawful age, a witness herein, called by the  
plaintiffs for the purpose of cross-examination  
pursuant to the Ohio Rules of Civil Procedure,  
being first duly sworn, as hereinafter certified,  
was examined, and testified as follows:

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CROSS-EXAMINATION

BY MR. CULLERS:

Q. Could you state your professional address,  
please?

A. 3125 Huntington Road, Shaker Heights, Ohio,

Q. Your residence address?

A, I'm sorry,

Q. That was your residence address?

A. Yes. **My** professional address would **be**  
**11100** Euclid Avenue, Cleveland, Ohio 44106.

Q. **Is** that the Rainbow Babies & Children's  
Hospital?

A. No, that's University Hospitals **of** Cleveland.

Q. What is your position now?

A. Now I'm finishing my chief residency in  
obstetrics and gynecology.

Q. I'm going to ask you some questions about the  
care and treatment provided to Monica Dixon during

1 her delivery of Michael Dixon, which occurred on  
2 3-14-95.

3 It's my understanding you had at  
4 least some involvement in that; do you recall that?

5 A. I have seen the paperwork. I don't recall  
6 the evening.

7 Q. Were you involved in that?

8 A. Yes.

9 Q. When you say "the paperwork," what are you  
10 referring to?

11 A. A copy of the medical record that I was  
12 provided.

13 Q. Is that a copy of the chart from 3-14-95?

14 A, Yes.

15 Q. Did you have an opportunity to review it in  
16 detail before today?

17 A. I did, for my involvement primarily.

18 Q. I would like to find out what the time frame  
19 of your involvement was.

20 The first thing I found I will tell  
21 you was in the history and physical section of the  
22 chart I have, which is an admit note; is that your  
23 first involvement with this patient?

24 A. No.

25 Q. Tell me when your first involvement was.

1 A. 3-11, 1995.

2 Q. What was the nature of your involvement  
3 on 3-11?

4 A. Apparently the patient presented to the  
5 screening room having contractions every three to  
6 five minutes, lasting seconds.

7 Q. Did you examine her?

8 A, I did.

9 Q. How long was she in the screening room?

10 A, From 2:10 a.m. until 4:30 a.m.

11 Q. How many times did you see her during that  
12 period of time?

13 A, A minimum of two.

14 Q. Could you read your notes, please?

15 A, My notes state that the patient had a  
16 nonstress test that showed the fetal heartbeat was  
17 140's to 150's, no contractions were seen, and her  
18 cervix was 3 to 4 centimeters dilated.

19 Q. Is there any information in your notes on  
20 that date about her prenatal history?

21 A. From this date?

22 Q. Yes.

23 A. None that I have indicated here,

24 Q. Would there have been any place in the chart,  
25 in the screening room flow sheet on 3-11-95, where

1       you would have indicated facts about her prenatal  
2       history?

3       A.       I'm not sure I understand the question,

4       Q.       Did you know anything about what transpired  
5       with her prenatal care as of 3-11-95?

6       A.       From this indication I don't. I don't know  
7       if I didn't know or whether I chose not to write it  
8       down.

9       Q.       On 3-11-95 was it your customary practice  
10       then to find out information about the patient's  
11       prenatal care when you examined them in the  
12       screening room?

13       A.       It's my practice with every patient to find  
14       out the prenatal care and course,

15       Q.       That would have been true obviously on  
16       3-11-95?

17       A.       Yes.

18       Q.       It's likely then on 3-11-95 you did inquire  
19       about the facts concerning her prenatal care?

20       A.       Yes.

21       Q.       I would like you to then turn to the admit  
22       note which is dated 3-14-95, have you found that?

23       A.       Yes.

24       Q.       What is the time?

25       A.       0025.

1 Q. This is your note, isn't it?

2 A. Yes.

3 Q. I take it to mean you examined her on that  
4 date?

5 A. My interpretation of this note is that  
6 Dr. Segal examined the patient.

7 Q. I see a signature line or a signature for you  
8 I believe in the lower right-hand corner?

9 I need you to say yes.

10 A. Yes. Sorry.

11 Q. Does that signature indicate that you  
12 reviewed this?

13 A. That I took the patient's history and I  
14 obtained all this information, with the exception  
15 that I did not examine her when she presented at  
16 this time, that another physician did.

17 Q. How can you tell from looking at this note  
18 that Dr. Segal is the one who examined her?

19 A. I did her physical exam excluding her pelvic  
20 exam, but if I don't do the pelvic exam I indicate  
21 who the physician was. I put per Segal, M.D.

22 Q. That is slightly above your signature?

23 A. Yes.

24 Q. Whose signature is to the **left** of yours?

25 A. Dr. Cynthia **Austin**.



1 Q. Did you have any discussions with her at the  
2 time that you were recording the information in  
3 this note, the OB admit note?

4 A. I don't recall at the present time. It's our  
5 customary practice to let all the people involved  
6 in the patient's care know about our patients who  
7 are admitted to labor and delivery.

8 Q. When you let other providers know about the  
9 patient, does that include somehow communicating  
10 the information that you were writing down on the  
11 OB admit note?

12 A. I'm not sure I understand what you are  
13 asking,

14 Q. It was a bad question probably.

15 I know that you obtained some  
16 information about the patient and you recorded it  
17 in the OB admit note, true?

18 A. Yes.

19 Q. Did you then communicate that information to  
20 Dr. Austin?

21 A. I don't recall, but that would have been the  
22 practice.

23 Q. So it's likely then that the information that  
24 you obtained and recorded on the OB admit note  
25 would have been communicated by you to Dr. Austin?

1 A. I think it's likely, yes.

2 Q. Is it likely that would have been  
3 communicated on the same day, on 3-14-95?

4 A. I would think so. I think the in-house  
5 attending physician and all the residents in the  
6 patient's care are aware of each patient who is  
7 admitted to labor and delivery.

8 Q. They would have been made aware on that date?

9 A. That would be my understanding, yes.

10 Q. In other words, I am just trying to find out  
11 the information you recorded on 3-14-95 on this  
12 note, was it communicated to Dr. Austin on that  
13 same date?

14 MR. NORCHI: It's already  
15 been asked and answered, but go ahead.

16 A. I would say it would be based on her  
17 signature here,

18 Q. I was asking you some questions earlier when  
19 you were referring to the screening room flow sheet  
20 about your awareness of the patient's prenatal  
21 care. I want to return to that, but I want you to  
22 refer to the OB admit note that you partially  
23 prepared.

24 If you will refer to approximately  
25 the center third of the page there is some

1 information regarding a glucose tolerance test; do  
2 you see that?

3 A. Yes.

4 Q. Could you read that, it starts with three,  
5 what does that say there?

6 A. Three hour glucose tolerance test, it's my  
7 abbreviation.

8 Q. What do the numbers signify?

9 A. Fasting blood sugar, three hours blood sugar,  
10 two hours blood sugar, and one hour blood sugar.

11 Q. Do those values meet the definition of  
12 gestational diabetes?

13 A. Generally gestational diabetes is defined as  
14 two abnormal blood sugars.

15 Q. Are there two here?

16 A. I'm trying to recall the three hour upper  
17 limit of normal, I think there are two abnormals.

18 Q. Are you certain?

19 A. No.

20 Q. In any event, you didn't indicate anywhere on  
21 this form that the patient had a gestational  
22 diabetic pregnancy, did you?

23 A. I did not give her that diagnosis. I said in  
24 her summary line at the top that she had elevated  
25 blood sugars with her pregnancy,

1 Q- Did you know that she was a gestational  
2 diabetic at the time you examined her on 3-11-95?

3 MR. NORCHI: I'm going to  
4 object. It's not established that she was a  
5 gestational diabetic on 3-11-95, but go ahead,

6 A. Could you repeat the question?

7 Q. Do you know whether the patient was a  
8 gestational diabetic on 3-11-95?

9 A. Based on these records I can't say that she  
10 was.

11 Q. You don't have any other independent  
12 knowledge whether she was or not?

13 A. No.

14 Q. On 3-14-95 do you know based on the  
15 information contained in your OB admit note whether  
16 the patient was a gestational diabetic?

17 A. Based on my admit note she had some  
18 borderline elevated blood sugars.

19 Q. Do you have an opinion based on your review  
20 of this now as to whether or not on 3-14-95 she was  
21 a gestational diabetic?

22 MR. NORCHI: Objection.  
23 Asked and answered. He told you he wasn't aware of  
24 what those particular numbers meant with the labs,  
25 but go ahead. I am going to object to the opinion

1 testimony anyway.

2 A. Can you restate your question?

3 MR. CULLERS: Read the  
4 question back.

5 -----

6 (Question read as follows: Do you have an opinion  
7 based on your review **of** this now as to whether or  
8 not on 3-14-95 she was a gestational diabetic?)

9 -----  
10 A. My opinion is that she has borderline  
11 elevated blood sugars.

12 Q. Were you aware on 3-14-95 that the patient  
13 was on a diet pursuant to the prenatal care that  
14 she had been given to control her weight gain?

15 A, Based on this information, no.

16 Q. Do you know whether she was on a diet for any  
17 reason as of 3-14-95?

18 A. Her other blood sugars indicated here, might  
19 go on with that, that she had some sort of  
20 surveillance.

21 Q. Is it something that is significant **to** know  
22 in assessing a patient, to understand these  
23 circumstances where she has come in?

24 A. Yes.

25 Q. It is **important**. All right.

1                    Could you read the first part of  
2                    that information where it says HPI?

3                    A.        22 year old gravida 1, para 0, complained of  
4                    contractions for two to three days. No loss of  
5                    fluid, no vaginal bleeding. She was feeling the  
6                    baby move. Pregnancy was -- uncomplicated  
7                    pregnancy to date. Seen earlier on 3-13, sent home  
8                    after no cervical change. Negative oxytocin change  
9                    test, elevated blood sugars with pregnancy.

10                  Q.        Then what does it say below that OB date?

11                  A.        Obstetrical dates, last menstrual period,  
12                  5-17-94; estimated date of confinement, 2-22;  
13                  ultrasound, nine and four-sevenths weeks; due date  
14                  3-12, dated 40 and two-sevenths weeks.

15                  Q.        Below that fraction?

16                  A.        OB history?

17                  Q.        Yes. What does that mean?

18                  A,        This is her first pregnancy.

19                  Q.        What does it mean then below that?

20                  A.        OB risks, I put none,

21                  Q.        What did that mean?

22                  A.        That I thought she was an uncomplicated first  
23                  time mother.

24                  Q.        I noticed that in the operative report,  
25                  obviously which you did not prepare, but I would

1     like you to refer to it, it indicates the  
2     pre-operative diagnosis was, among other things,  
3     macrosomic; have you seen that?

4     A.     Yes.

5     Q.     At any point during your treatment of this  
6     patient were you of the opinion that the fetus was  
7     macrosomic?

8     A.     No.

9     Q.     Were you of the opinion that the fetus was  
10    not macrosomic?

11    A,     I'm not sure I understand your question.

12    Q.     Did you have any opinion whatsoever regarding  
13    whether or not the fetus was macrosomic?

14    A.     No.

15    Q.     Did you ever have any discussion with  
16    Dr. Krietsky about whether or not macrosomia was  
17    present?

18    A.     I don't recall,

19    Q.     Did you have any discussions with anyone  
20    about macrosomia at all?

21    A.     No, or not that I recall, it's not indicated  
22    in the chart.

23    Q.     As of 3-14-95 did you have any understanding  
24    of any relationship between gestational diabetes  
25    and the occurrence of macrosomia?

1 A. I'm not sure I understand your question.

2 Q. Did you know what macrosomia was as of  
3 3-14-95?

4 A. I think so.

5 Q. Are you sure?

6 A. Are you asking me based on the chart here or  
7 my knowledge?

8 MR. NORCHI: He is just  
9 asking a general question.

10 Q. I just need to know if you knew what  
11 macrosomia was as of 3-14-95.

12 A. Yes.

13 Q. Did you have an understanding as of 3-14-95  
14 about the obstetrical risks associated with  
15 gestational diabetes?

16 A. Yes.

17 Q. What were they?

18 A. That patients who had uncontrolled **blood**  
19 sugars could have larger gestational sized infants.

20 MR. NORCHI: Is that what  
21 you wanted, **or** all possibilities? I'm not trying  
22 to limit the scope of your questioning.

23 Q. Well, the nature of my question was what did  
24 you understand **to** be the risks associated with  
25 gestational diabetes as of 3-14-95, that was my



1 question, and I don't know if you answered that by  
2 what you told me already, or if you want to expand  
3 on that if you want, to you may.

4 A. In utero the fetus could be large for  
5 gestational age, and a poorly controlled diabetic  
6 could have complications of delivery,

7 Q. That was something you were aware of as of  
8 3-14-95?

9 A, Yes.

10 Q. How is that something you knew about, **from**  
11 your training or your schooling?

12 A. Both,

13 Q. Why does that fact that a baby could be large  
14 for a gestational age fetus create a risk?

15 A. A risk for what?

16 Q. I asked if there were any risks that you were  
17 aware of that were associated with gestational  
18 diabetes and you said that -- I am wondering why a  
19 large gestational age infant yields a risk.

20 MR. NORCHI: I don't know if  
21 the word "risk" was used.

22 Can you answer the question? If  
23 you understand the question, answer it; if you  
24 don't, Mr. Cullers will rephrase it for you. Go  
25 ahead.

1 Q. Obviously the word risk means something or at  
2 least meant something to you on 3-14-95, true?

3 A. Yes.

4 Q. What did it mean to you?

5 A. A patient with poorly controlled blood sugar  
6 could have a large gestational size infant and that  
7 could pose risks for delivery.

8 Q. Now, on your OB admit note, obviously you  
9 didn't indicate anything about the fact that a  
10 large for gestational age infant was a concern,  
11 true?

12 A, That's correct.

13 Q. Is there any reason why you didn't indicate  
14 that?

15 A. In looking back on the record it may have  
16 been because A, I didn't do her pelvic exam at the  
17 time of admission; and B, it was my understanding  
18 from her laboratory values that she had  
19 well-controlled blood sugars during pregnancy, but  
20 had marginal screening tests.

21 Q. Where did you find the information that she  
22 had well-controlled blood sugars?

23 A. Fasting, two hour blood sugar listed here.

24 Q. Did you go back to see if her blood sugar  
25 levels were well controlled during her prenatal

1     care?

2     A.     This was during her prenatal care.

3     Q.     Where did you get that information from?

4     A.     From the computer, I would imagine.

5     Q.     So I take it from your testimony that you  
6     made a determination, while you were writing the  
7     information on the OB note, that there were no  
8     obstetrical risks that you had noted that were  
9     related to gestational diabetes?

10    A.     Yes.

11    Q.     What other information do you have on here  
12    below where it says OB risks, where it says PM?

13    A.     Past medical history, none; past surgical  
14    history, she had a breast reduction and an abscess  
15    that apparently was drained.

16    Q.     Below that?

17    A.     She stated she was allergic to penicillin,  
18    she didn't know the reaction that happened, She  
19    took prenatal vitamins, didn't smoke cigarettes,  
20    drink alcohol, or use drugs.

21    Q.     If you would go down to PE, read that for  
22    me.

23    A.     Physical exam: Temperature 37.1; blood  
24    pressure 130 over 80; respiration, 22; her lungs  
25    were clear on auscultation. She had a regular rate

1 and rhythm to her heart, her abdomen was soft and  
2 nontender.

3 Q. To the right, what is that?

4 A. FH, fundal height measurement.

5 Q. You didn't include that in there?

6 A. That is correct.

7 Q. Any reason why?

8 A. I don't recall.

9 Q. What is to the right in this little block  
10 where it says per Segal?

11 A. Sterile speculum exam/vaginal exam, 4 to  
12 5 centimeters dilated, high station

13 Q. Does the 4 to 5 centimeters of dilation when  
14 appearing at the same time as a high station  
15 indicate fetopelvic disproportion in any way?

16 A, No.

17 Q. What does it say above that, positive --  
18 right above vaginal exam?

19 A. Positive occasional variable decels,

20 Q. Right above that?

21 A. Contractions, Q. four to five minutes, fetal  
22 heart rate in 150's.

23 Q. The lower left-hand corner?

24 A. Assessment and plan, 40 and two-sevenths  
25 weeks.

1 Q. Below that?

2 A. Epidural, admit and rupture of membranes.,

3 Q. What does rupture of membranes mean, it  
4 already happened?

5 A. No, that would be my plan of things to do.

6 Q. Why did you indicate that as part of your  
7 plan?

8 A. It's a customary procedure to aid in the  
9 laboring process,

10 Q. When I was asking you earlier about your  
11 understanding of obstetrical risks that may be  
12 associated with gestational diabetes, you said  
13 something about a large for gestational age fetus;  
14 do you recall that?

15 A. Yes.

16 Q. What is it about that fact, a large for  
17 gestational age fetus, that yields a risk?

18 A, The risks are primarily associated with  
19 delivery through the birth canal and glucose, fetal  
20 glucose management after delivery.

21 Q. What risks are associated with the delivery  
22 for a large gestational age infant through the  
23 birth canal?

24 A, Arrest of active phase of labor, and  
25 difficulties in delivering the fetus.

1 Q. Are these things that you were aware of as  
2 of 3-14-95?

3 A. Yes.

4 Q. Tell me as of 3-14-95 your level of  
5 experience.

6 A. In what?

7 Q. Were you a first year resident?

8 A. Yes. Level of experience in what?

9 Q. That's what I meant. I just wanted to know  
10 what your position was or title,

11 How many labor and deliveries had  
12 you been involved in as of 3-14-95?

13 A. I don't know for sure, probably around 150.

14 Q. I want to focus on an aspect of what your  
15 customary practice was as of 3-14-95.

16 When you are admitting a patient  
17 you are preparing a note such as your OB admit note  
18 here, and you are inquiring about the patient's  
19 prenatal care; do you obtain a copy of the chart  
20 from her prenatal care?

21 A. Yes.

22 Q. Is that something that you get, that you have  
23 in hand at the time you are writing down the  
24 information that you take down when you admit a  
25 patient?

1 A. Generally, yes.

2 Q. Where does that come from, where is that  
3 kept?

4 A. On labor and delivery.

5 Q. So it's not something that is difficult to  
6 obtain?

7 A. Generally, no,

8 Q. It certainly wasn't uncommon as of 3-14-95,  
9 you were able to have it actually when you are  
10 writing down information about the patient?

11 A. I don't recall whether I had a copy of her  
12 chart or whether this was the information she  
13 presented to me,

14 Q. What was your usual practice back then on  
15 3-14-59, to actually have a copy of the chart?

16 A. Absolutely, if it was available.

17 Q. If it was available the likelihood is you had  
18 it with you when you wrote this information down on  
19 the OB admit note?

20 A. Yes.

21 Q. It is likely some **of** the information about  
22 her history you obtained from that chart?

23 A, Yes, if it was available.

24 Q. Would you feel uncomfortable not having **it**?

25 A. I'm not sure how to answer that,

1 Q. If you were taking down a patient's history  
2 at the time that she was being admitted, wouldn't  
3 you feel uncomfortable writing down facts about her  
4 history without having the opportunity to review  
5 her chart from her prenatal care?

6 A. I would prefer her chart, yes.

7 Q. Earlier I was asking you about the time frame  
8 of your involvement with this patient, I got the  
9 first end of it, but I didn't get the second end.

10 I know you started on 3-11, but  
11 when was the last time you had any involvement with  
12 Monica Dixon?

13 A. The last entry into the chart was 3:45.

14 Q. That was your progress note?

15 A, Yes, but I think myself and Dr. Segal were  
16 both taking care of her throughout the early hours  
17 of 3-15,

18 Q. Up until when?

19 A. Probably a change of shift at 7:00 a.m.

20 Q. Do you have any specific recollection today  
21 of being involved in her care at any point after  
22 3:45 a.m. on 3-14?

23 A. No,

24 Q. I would like you to refer to your progress  
25 notes, if you would. Is the first one that you



1 have recorded at 2:10 a.m.?

2 A. Yes. Patient without complaints, epidural in  
3 place. I listed her vital signs, her cervical  
4 dilation, and her nonstress test, and then I  
5 artificially ruptured her membranes at 2:10 a.m.  
6 for thick meconium stained fluid.

7 Q. So you actually did a vaginal exam at 2:10?

8 A. Yes.

9 Q. That's when you arrived at the value you  
10 indicated for station?

11 A. Yes, that's my exam.

12 Q. And for dilatation also?

13 A. Yes.

14 Q. Did you do a vaginal exam when you were  
15 preparing the information contained in your: admit  
16 note?

17 A. No, Dr. Segal did.

18 Q. Do you know whether station has changed  
19 between his vaginal exam and then yours at  
20 2:10 a.m.?

21 A. I can't say because I didn't **examine** her, but  
22 the notation is different.

23 Q. The notation seems to indicate a high  
24 station?

25 A. Correct.

1 Q. What does that mean?

2 A. I don't know, I don't know what Dr. Segal  
3 meant by that,

4 Q. If you would have reviewed that chart or that  
5 note on 3-14-95, what would you have understood  
6 that to mean?

7 A. That the station was probably greater than  
8 minus 2.

9 Q. Greater than minus 2; is that what you said?

10 A. Yes.

11 Q. When you are determining station, how **do** you  
12 do that? Or I should ask it this way: When you  
13 were determining station on 3-14-95 at 2:10 a.m.,  
14 how did you do it?

15 A. I performed a pelvic exam and assessed the  
16 presenting part of the fetus and internal bone  
17 pelvis.

18 Q. What is the presenting part of the fetus?

19 A. Vertex -- I'm not sure I understand your  
20 question.

21 Q. You have to find the relationship of the  
22 presenting part of the fetus with the ischial  
23 spines of the mother, true?

24 A. Yes.

25 Q. **What is the presenting part that you are**

1 looking for on the fetus?

2 A. You want the medical term?

3 Q. Yes.

4 A. The biparietal diameter,

5 Q. Where is it? Show me.

6 A. Right here,

7 Q. You can feel that with your hand?

8 A. Yes.

9 Q. Can you go down to your next note at

10 3:45 a.m.?

11 A. Painful contractions, listed the patient's

12 vital signs, her cervical exam, and her nonstress

13 test.

14 Q. Her cervical exam, she is 5 centimeters

15 dilated?

16 A. Yes.

17 Q. She is having painful contractions; is **that**

18 what you said?

19 A. Yes,

20 Q. Is she in active labor at 3:45 a.m.?

21 A. No.

22 Q. How do you know that?

23 A. I'm not sure if she is in labor at all.

24 Q. What would you need to see to feel confident

25 in **determining** that she was in active labor?

1 A. I would need to see adequate contractions and  
2 cervical change.

3 Q. You mean you needed to see cervical change  
4 beyond the 5 centimeters of dilatation that you see  
5 at 3:45 a.m.?

6 A. Yes, combined with contractions.

7 Q. How can you tell by looking at your note at  
8 3:45 a.m. that she wasn't having forceful  
9 contractions to meet the definition of active  
10 labor?

11 A. At 3:45 she didn't have an internal pressure  
12 catheter. She did not have an internal pressure  
13 catheter in place.

14 Q. There was no way to measure the force of the  
15 contractions?

16 A. No.

17 Q. That doesn't mean there wasn't a forceful  
18 contraction?

19 A. I don't know, **it** could have been.

20 Q. You just don't know because **it** wasn't  
21 measured?

22 A. I can't say. **It** could have been.

23 Q. If **it** would have been sufficiently forceful  
24 as of 3:45, the fact that she was 5 centimeters  
25 dilated in conjunction with forceful contractions,

1 would that meet the definition of labor?

2 A. Restate that, please.

3 Q. If she was having sufficiently forceful  
4 contractions at 3:45 a.m., and she was  
5 5 centimeters dilated that would meet the  
6 definition of labor?

7 A. I define labor as cervical change at the time  
8 with adequacy of contraction,

9 Q. Over what period of time for cervical change?

10 A. Generally that's in a period of two hours,

11 Q. You said that you continued to be involved  
12 with Dr. Segal after caring for this patient at  
13 3:45; you said that earlier?

14 A. I believe so. I don't have further **notes** in  
15 the patient's chart, but that was the customary  
16 practice.

17 Q. That's what I want to find out.

18 Why is it that you may be involved  
19 after 3:45 a.m.?

20 A. Because Dr. Segal and myself were the  
21 two residents on labor and delivery that evening.

22 Q. Is there any way you can tell by looking at  
23 Dr. Segal's note of 5:15 a.m. whether the patient  
24 is in active labor?

25 A. She would appear **to** be because she had

1 cervical change.

2 Q. Is it your opinion that as of 5:15 a.m. on  
3 3-14 that Monica Dixon was in active labor?

4 A. Yes,

5 Q. As you sit here today do you recall anything  
6 about this patient's care independent of your  
7 reviewing the chart?

8 A. No,

9 Q. Do you remember anything about what she  
10 looked like?

11 A. No.

12 Q. Is there anything at all about her care that  
13 sticks out in your memory that you can recall  
14 without having to review the chart?

15 A. No.

16 Q. Do you remember any of the discussions that  
17 you had with Dr. Segal at any point?

18 A. No.

19 Q. Did you have any discussions with him based  
20 on your customary practice?

21 **A. Based** on my customary practice, yes.

22 Q. Would you have been continually involved with  
23 him in discussing the status of the patient?

24 A. Yes, he was my senior resident.

25 Q. Would he have been a third year resident?

1 A. Second year.

2 Q. Would you have had any discussions with  
3 Dr. Austin during your involvement with this  
4 patient?

5 A. Did I or would I have?

6 Q. Well, do you recall any?

7 A. No.

8 Q. Consistent with the normal practice would you  
9 have had any discussions with her?

10 A, The normal practice is to make sure that the  
11 two residents on labor and delivery, the chief  
12 resident and the attending physician, all know  
13 about the patient.

14 Q. How does that happen, are there specific  
15 times when Dr. Austin would have discussions with  
16 you?

17 A. Assigned times?

18 Q. Yes.

19 A. No.

20 Q. How would it generally work?

21 A, Just by word-of-mouth on labor and delivery.

22 Q. Could you turn to the consent for treatment  
23 form; that contains your signature?

24 A. That's a question?

25 Q. Yes.

- 1 A. Yes.
- 2 Q. Is this something that you filled out?
- 3 A. Yes.
- 4 Q. Do you recall doing this?
- 5 A. No.
- 6 Q. Do you recall what your normal practice was  
7 when you filled out one of these back in March  
8 of 1995?
- 9 A. Yes.
- 10 Q. Tell me how you went about doing that with a  
11 patient.
- 12 A. I would tell the patient that she is being  
13 admitted to labor and delivery for our plan of  
14 labor, vaginal delivery, and that there is always  
15 the possibility of a Cesarean section.
- 16 If she requires anesthesia this  
17 would be a consent form that would include that,  
18 and that we never anticipate the use of blood  
19 products, but were they to be necessary this would  
20 be included on your consent.
- 21 Q. That's what you do, explain that to her, show  
22 her this form?
- 23 A. Yes.
- 24 Q. Did you read this whole thing to her?
- 25 A. No, I let the patient read it.



1 Q. Did you have any discussions with her about  
2 any potential risks associated with the fact that  
3 the child ma'y be a large for gestational age fetus?

4 A. Can you restate the question?

5 Q. Was there any discussion about any suspicion  
6 that you may have had that the patient or that the  
7 fetus was a large for gestational age fetus?

8 A. Let **me** rephrase your question. I'm not sure  
9 I understand it,

10 Did I discuss with the patient  
11 whether her fetus was large for gestational age?

12 Q. Yes. Did you discuss that with her?

13 A. No,

14 Q. Is it because you didn't think that was the  
15 case?

16 A. Yes.

17 Q. When you explained the procedure of **a** vaginal  
18 delivery, was there any discussion at all about  
19 complications that might arise as a result of the  
20 baby being a large for gestational age baby?

21 A. No.

22 Q. You remember that to be the case?

23 A. No, that's not something I customarily  
24 include in my admission consent form discussion,

25 Q. In this particular instance, based **on** the

1 information you had about this patient, did you  
2 have any reason to believe that there was a  
3 potential complication that would arise as a result  
4 of this being a large for gestational age baby?

5 A. According to my admission note I make no  
6 indication that I thought the baby was large for  
7 gestational age; therefore, I would not have any  
8 discussion with her regarding that.

9 Q. Did you have any discussions with her about  
10 any possible risks that could be associated with a  
11 gestational diabetic pregnancy?

12 A, No, not that I can tell,

13 Q. What causes you to say no? You didn't have  
14 those discussions as far as you can tell?

15 A. My admission note does not indicate that **my**  
16 impression was that the baby was large for  
17 gestational age; and therefore, I wouldn't have  
18 discussed something that I didn't find to be  
19 present.

20 MR. CULLERS: Off the  
21 record.

22 -----

23 (Discussion had off the record,)

24 -----

25 BY MR. CULLERS:

1 Q. At the time that you were filling out the  
2 consent form, did you discuss with the patient the  
3 potential risks that could be associated with a  
4 gestational age -- a gestational diabetic  
5 pregnancy?

6 A. No, probably not,

7 Q. Why do you reach that conclusion?

8 A, That's not something I customarily discuss  
9 with the patient at the time of their admission to  
10 labor and delivery.

11 Q. With respect to this particular patient, did  
12 you have any reason to believe that there were  
13 potential risks associated with a gestational  
14 diabetic pregnancy?

15 A. There are potential risks to a diabetic  
16 pregnancy.

17 MR. NORCHI: How about in  
18 this particular patient?

19 THE WITNESS: In this  
20 particular patient I was unimpressed by her values  
21 and physical exam.

22 Q. Based on your testimony it's my understanding  
23 that you are saying that you didn't have reason to  
24 believe, at the time the patient was admitted, that  
25 she potentially could have complications related to

1 a gestational diabetic pregnancy, true?

2 A. I'm getting confused between the theoretical  
3 and what I said to the patient.

4 Q- I know you don't remember anything you said  
5 to the patient at this point. So as the basis for  
6 your information to answer these questions I am  
7 going to rely on your practice that you would have  
8 had in place on 3-14-95,

9 A. Okay.

10 Q. With that in mind, it's my understanding from  
11 what you said earlier that you typically would not  
12 as a matter of course explain the complications  
13 attendant to a gestational diabetic pregnancy?

14 A. That is correct,

15 Q. Then, however, assuming that if you had  
16 information that caused you to believe that there  
17 was a gestational diabetic pregnancy with a  
18 particular patient, that might trigger a discussion  
19 at that point with risks associated with that  
20 individual?

21 MR. NORCHI: That's the  
22 theoretical question.

23 A, I generally don't discuss delivery risks with  
24 patients despite my knowledge of the potential.

25 Q. Why not?

1 A. I feel that's what I'm trained to observe and  
2 note, and it's complicated individualized  
3 assessment.

4 Q. If you had information of treating a patient  
5 who had a gestational diabetic pregnancy, you are  
6 aware that certain risks are attendant to that, you  
7 would explain that to them?

8 A. I don't know how my explaining those risks  
9 would have changed what I did, so I don't often --  
10 I don't review all of the risks at the time of  
11 their admission.

12 Q. Do you recall having any discussions with any  
13 of the providers involved in this patient's care  
14 about gestational diabetes?

15 MR. NORCHI: Objection.

16 Asked and answered. You can answer it again.

17 A. State the question again,

18 Q. Do you recall having any conversations with  
19 any of the providers involved in Monica Dixon's  
20 care about gestational diabetes?

21 A, I have no present recollection. My practice  
22 was to discuss it with the more senior residents.

23 Q. Based on your review of this chart, is there  
24 any information in there that causes you to believe  
25 today that you may have had a discussion with any

1 of these providers about gestational diabetes?

2 A. I'm not sure that I know what you're asking.

3 Q. I'm asking based on your review of the  
4 information here, is it likely you had a discussion  
5 with any of the providers that this lady may have  
6 had a gestational diabetic pregnancy?

7 A. I would say that is likely.

8 Q. When is it likely that such discussions would  
9 have occurred?

10 A. Probably after I summarized -- after her  
11 admission, history, and physical information.

12 Q. Would that have been on 3-14-95?

13 A. Yes.

14 Q. Would that have been before the delivery of  
15 the baby?

16 A. Yes.

17 Q. Without trying to pinpoint you to exactly  
18 when you would have done that, would it have been  
19 simultaneously or spontaneously with your  
20 preparation of the information contained in the OB  
21 note?

22 A. I would think that would be reasonable to  
23 conclude that.

24 Q. So that's when any such discussions would  
25 have occurred about gestational diabetes?

1 A. Yes.

2 Q. Do you recall having any discussions with any  
3 of Monica Dixon's providers about whether a  
4 C-section may be appropriate?

5 A. No.

6 Q. Do you know anything about the delivery  
7 itself?

8 A. I briefly reviewed the note from  
9 Dr. Krietsky.

10 Q. What do you recall about it?

11 MR. NORCHI: You can turn to  
12 it.

13 A. It was a vacuum assisted delivery, with the  
14 delivery of a 4137 gram infant.

15 Q. You weren't involved in any way in the actual  
16 details of the delivery, were you?

17 A, No.

18 Q. Did you have any discussions with  
19 Dr. Krietsky about the details of the delivery at  
20 any point?

21 A. No.

22 Q. Not even afterward?

23 A. No.

24 Q. Do you recall having any discussions with any  
25 of the providers about abnormal progress of labor

1 with this patient?

2 A. Again, I can only answer what my practice  
3 would be because my discussions aren't indicated in  
4 the chart.

5 Q. What would that be?

6 A. To discuss the patient's cervical exam with  
7 Dr. Segal.

8 Q. During the time frame that you believe you  
9 may have been involved with Dr. Segal after  
10 3:45 a.m., is there anything in the notes that  
11 causes you to believe that you may have had a  
12 discussion with him about the abnormal progress of  
13 labor with this patient?

14 A. I'm not sure that I know what you are asking.

15 Q. Can you turn to the progress of labor chart?  
16 It's back with the labor notes in my chart, the  
17 copy of the chart I have, It looks like this.  
18 There it is.

19 We know the last note occurred at  
20 3:45 a.m.; is that right?

21 A. Yes.

22 Q. You continued to be involved. You set up  
23 until perhaps 7:00 a.m. when there was a shift  
24 change?

25 A. Yes, that was my shift.



1 Q. If you look at the progress of labor chart  
2 you would agree with me, wouldn't you, that station  
3 at least as it's charted didn't change between  
4 approximately 2:50 a.m. and seven o'clock a.m.?

5 A. Station or dilation?

6 Q. Station, it's the X's.

7 A. Are you asking me to interpret this chart  
8 or --

9 Q. No. The question was: Did station change  
10 between approximately 2:50 a.m. and  
11 seven o'clock a.m., at least as it's charted here  
12 on the progress of labor chart?

13 A. As it's charted here it stayed the same,  
14 Dr. Segal's note, plus 1 station at 7:00 a.m.

15 Q. During that period of time between  
16 approximately 2:50 a.m. and seven o'clock a.m., is  
17 it likely that you would have had a discussion with  
18 Dr. Segal about the progress of labor?

19 A. Yes, because I placed internal monitors.

20 Q. What time did you do that?

21 A. 3:45.

22 Q. Is it likely that at some point between  
23 2:50 a.m. and seven o'clock a.m. that you would  
24 have had a discussion with Dr. Segal about the fact  
25 that there may be abnormal **progress** of labor?

1                   MR. NORCHI:                   You **are** kind of  
2     jumping around. I'm going to object, You are  
3     assuming he has somehow determined that there is an  
4     abnormal progress of labor. At one point you said  
5     did you talk about progress of labor, he said yes,  
6     and now --

7     Q.        I guess I changed the question a little bit  
8     to find out if there was a discussion you had with  
9     Dr. Segal to find out whether or not the progress  
10    of labor was abnormal,

11    A.        I would say based on the notes that my  
12    thinking was I think we should measure the adequacy  
13    of her contractions and see if her cervical  
14    dilation progressed.

15    Q.        I take it to mean it's not likely that you  
16    would have had a discussion with Dr. Segal?

17    A.        No, the opposite of that. I think I would  
18    have had a discussion with Dr. Segal.

19    Q.        Do you think that during any of those  
20    discussions, or that discussion with Dr. Segal,  
21    that it was determined or suggested that the  
22    progress of labor was abnormal for everything  
23    discussed like that?

24    A.        I don't know that I would label it abnormal.  
25    I would want to see that she changed her cervix,

1 and I would want to monitor her ability to do  
2 that, The fact she didn't change her cervix led me  
3 to more carefully monitor her contractions.

4 Q. When did she not change her cervix, what axe  
5 you talking about?

6 A. My notes from 2:10 a.m. and 3:45 a.m.

7 Q. She didn't have any additional dilatation  
8 between those two points in time?

9 A. No.

10 Q. During your involvement between 2:10 a.m. and  
11 seven o'clock a.m., did you ever make any  
12 determination that the fact that station remained  
13 static **was** a cause for concern?

14 A. No, not that I recall.

15 Q. Based on your review of the information in  
16 your notes and based on the information contained  
17 in the vaginal exams, is it likely you would have  
18 had a discussion with Dr. Segal about the fact that  
19 station had not changed for a period of a few  
20 hours?

21 A. I think that would be one of the factors that  
22 he and I would have both been aware of.

23 Q. **Is** it something you would have discussed with  
24 him?

25 A. **Yes.**

1 Q. Why would that have been something that the  
2 two of you discussed?

3 A. We would both be on the same page in terms of  
4 her dilation and descent.

5 Q. Why would the fact that the descent didn't  
6 change for a period of several hours be of  
7 significance to you and Dr. Segal?

8 A, I'm not sure how much significance it was. I  
9 think it's part of the whole picture of labor,

10 Q. Did it have any significance at all to you?

11 A. It's a requirement for delivery.

12 Q. I guess I don't understand that answer,

13 A, You have to completely dilate and descend the  
14 fetal head.

15 Q. Before the baby can deliver?

16 A. Yes.

17 Q. If station doesn't change for four hours,  
18 does that fact that it hasn't changed cause any  
19 concern to you?

20 A. No, I don't think the patient is in **labor**,

21 Q. When do you think that active labor began?

22 A. Sometime between **3:45** and **5:15**.

23 Q. Does the fact that station doesn't change at  
24 least according to the vaginal exams and the  
25 progress of labor chart between **5:00** and **7:00 a.m.**

1       cause any concern to you?

2       A.       It does appear to change, it goes from 0 to  
3       plus 1.

4       Q.       Are you talking about Dr. Segal's progress  
5       note?

6       A.       Yes.

7       Q.       At seven o'clock a.m.?

8       A.       Yes.

9       Q.       Will you look at Dr. Krietsky's note of  
10       eight o'clock?

11       A.       Yes.

12       Q.       If you have read the information regarding  
13       her vaginal exam on 3-14-95, what would you have  
14       understood station to have meant?

15       A.       By her exam that was between 0 and plus 1.

16       Q.       Somewhere between 0 and plus 1?

17       A.       Yes.

18       Q.       Is it fair to say that station had changed  
19       less than 1 centimeter between five o'clock a.m.  
20       and eight o'clock a.m.?

21       A.       Somewhere around there, it's a subjective  
22       exam.

23       Q.       Does the fact that it changed only that much  
24       cause any concern?

25       A.       I think it's combined with the change in her

1       cervical dilatation.

2       Q.       So it doesn't cause concern?

3       A.       It causes some concern but it's weighed with  
4       her change in cervical dilation and the overall  
5       progress.

6       Q.       What is the concern caused by the fact that  
7       station changes only about a centimeter during a  
8       three hour or four hour period?

9       A.       Generally, the period of most rapid descent  
10       is somewhere after 7, 8 centimeters. I don't know  
11       if it causes a lot of concern, but it poses some.

12       Q.       The fact that it poses some concern, why does  
13       it cause some concern; what is it about that fact  
14       that causes some concern?

15       A,       Because the fetal head has to descend into  
16       the maternal pelvis in order to deliver.

17       Q.       The fact that it hasn't descended faster than  
18       that indicates something that is a negative?

19       A.       What do you mean by "negative"?

20       Q.       You said it causes some concern in response  
21       to my question what is the significance of the fact  
22       that the station changes 1 centimeter over a three,  
23       four hour period of time. I'm trying to figure out  
24       why you said it causes some concern. The fact that  
25       **it doesn't change, why does that cause concern?**

1 A. I'm not sure whether you want me to answer  
2 theoretically or in terms of this --

3 Q. In terms of this labor and delivery.

4 A. I'm not sure how to answer.

5 Q. Because of the question or --

6 A. Yes.

7 Q. What I'm trying to figure out is if there may  
8 have been any discussion that you would have had  
9 with either Dr. Segal or some of the other  
10 providers about the fact that -- the fact of the  
11 descent of the fetal presenting part did not change  
12 for a period of three, four hours or so, and the  
13 only way I can do that is having you review the  
14 chart and observe those facts about station and  
15 about the progress of labor.

16 My question is: Does the fact that  
17 station doesn't change or only changes 1 centimeter  
18 between -- or for a period of three or four hours  
19 cause any concern with this patient?

20 A. It causes some concern, but she continues to  
21 dilate her cervix.

22 Q. Now what I want to know is why does it cause  
23 some concern?

24 A. Because the normal progress of labor would  
25 result both in complete dilation of the cervix and

1 the descent of the fetal head.

2 Q. So there was something about the situation  
3 with Monica Dixon that was abnormal?

4 A. Are you asking me to comment on her ultimate  
5 station?

6 Q. No, No.

7 I'm asking you if the fact that  
8 station didn't change for a period of three or  
9 four hours is abnormal,

10 A. My reading of this chart is that the patient  
11 entered the active phase of labor after 3:45 and  
12 though initially she has no change of station she  
13 goes on to plus 1 station.

14 Q. So you are saying there was nothing abnormal  
15 about descent in the progress of this labor?

16 A. Her descent may have been slower but she was  
17 able to bring the baby to the plus 3 station at the  
18 time of delivery.

19 Q. When descent is slower than you would  
20 normally expect, does that indicate anything of  
21 significance to you?

22 A. If it's slower but she is able to descend the  
23 fetal head, it doesn't have much significance to  
24 me.

25 I noticed that you reviewed the operative



1 report just then when you were answering the  
2 question.

3 A. Yes.

4 Q. That was the one prepared by Dr. Krietsky?

5 A. Yes.

6 Q. In her report she indicates that macrosomia  
7 was suspected, and that is something we talked  
8 about earlier; do you recall that?

9 A, Yes.

10 Q. Do you know when that became suspected, when  
11 macrosomia became suspected?

12 MR. NORCHI: By

13 Dr. Krietsky?

14 MR. CULLERS: By anyone.

15 Q. Do you know?

16 A. No.

17 Q. Do you believe that this infant was  
18 macrosomic?

19 A. No.

20 Q. Do you believe that the size of the fetus had  
21 anything to do with the fact that descent was  
22 slower than you would ordinarily expect?

23 A. It could have.

24 Q. How does that happen?

25 A. A fetus, if it's -- the fetal size would be a

1 variable in descent of the fetus through the  
2 maternal pelvis.

3 Q. Because if it's bigger it has more difficulty  
4 potentially?

5 A. Yes.

6 Q. Do you recall any discussions with Dr. Segal  
7 about the fact that the progress of labor may have  
8 been slower than normal because of the size of the  
9 fetus?

10 MR. NORCHI: Objection.

11 A. No.

12 Q. You don't recall any or there were none?

13 A. I don't recall any and I didn't indicate that  
14 in my note.

15 Q. Based on your review of the notes, is it  
16 likely that would not have been a subject of a  
17 discussion?

18 A. Can you rephrase that?

19 Q. Based on your review of what is contained in  
20 the chart, **is** it likely that you would have had a  
21 discussion with Dr. Segal about the size **of** the  
22 baby somehow having an impact upon the progress **of**  
23 labor being slower than you would normally expect?

24 That was a pretty bad question.

25 Let me try to ask it in **a** more articulate way, if I

1 can.

2 Based on your review of the  
3 information in the chart, do you think that it's  
4 likely that you would have had a discussion with  
5 Dr. Segal wherein one of you stated something to  
6 the effect that the size of the fetus caused the  
7 progress of labor to be slower than you would have  
8 ordinarily expected?

9 A. Based on my notes, no.

10 Q. Is there anything in the record that causes  
11 you to believe that you might have had such a  
12 discussion?

13 A. About the size of the fetus?

14 Q. Being the reason why the progress of labor  
15 was slower than you would ordinarily expect?

16 A. No.

17 Q. I noticed there **was** an ultrasound that was  
18 done, did you have anything to do with that?

19 A. When?

20 Q. 3-13. Can you turn to it?

21 A. That's not part of this.

22 Q. I was going to ask you why it was done.  
23 3-13-95, 1400.

24 MR. NORCHI: Do you have  
25 times? That was the **earlier admission**.

1 A. This is from 3-11.

2 MR. NORCHI: She came in  
3 earlier in the day on 3-13.

4 Q. Do you know why this would have been done?

5 A. Can I see **it**?

6 Q. Sure.

7 A. It was to check **for** amniotic fluid volume,

8 Q. Fetal weight isn't indicated on that, is **it**?

9 A. No.

10 MR. CULLERS: That's all --  
11 oh, wait.

12 Q. Where did you go to medical school?

13 A. Here, Case Western Reserve,

14 Q. You graduated in?

15 A. 1994.

16 Q. This is your fourth year of residency?

17 A. Yes.

18 Q. You have one after that?

19 A. No,

20 Q. This is **it**?

21 A, Yes.

22 MR. NORCHI: He's done.  
23 Officially done, right?

24 THE WITNESS: Yes.

25 Q. Just **finished**?

1 A. Yes.

2 Q. Where do you plan to practice?

3 A. Geauga County.

4 Q. Is there a practice group that you are going  
5 to join?

6 A. Yes.

7 Q. What is the name of it?

8 A. University Primary Care Physicians. I don't  
9 know beyond that.

10 Q. Have you ever been involved in any situation  
11 where you have ever been involved in any  
12 litigation?

13 A. No.

14 Q. Have you ever been involved in the management  
15 of labor and delivery of a child where the child  
16 had a resulting Erb's palsy?

17 A. No.

18 Q. Have you ever been deposed before?

19 A. No.

20 MR. CULLERS: That's it.

21 Thank you.

22 MR. NORCHI: The doctor will  
23 read the transcript of the deposition.

24 -----

25 (Deposition concluded; signature not waived.)

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# ERRATA SHEET

NOTATION

PAGE / LINE


I have read the foregoing transcript and  
the same is true and accurate,

\_\_\_\_\_  
JOHN GRIFFITH, M.D.

1 The State of Ohio, .

2 County of Cuyahoga.

CERTIFICATE:

3 I, Kris A. Adorjan, Notary Public within and  
4 for the State of Ohio, do hereby certify that the  
5 within named witness, JOHN GRIFFITH, M.D., was by  
6 me first duly sworn to testify the truth in the  
7 cause aforesaid; that the testimony then given was  
8 reduced by me to stenotypy in the presence of said  
9 witness, subsequently transcribed onto a computer  
10 under my direction, and that the foregoing is a  
11 true and correct transcript of the testimony so  
12 given as aforesaid. I do further certify that this  
13 deposition was taken at the time and place as  
14 specified in the foregoing caption, and that I am  
15 not a relative, counsel or attorney of either  
16 party, or otherwise interested in the outcome of  
17 this action.

18 IN WITNESS WHEREOF, I have hereunto set my hand and  
19 affixed my seal of office at Cleveland, Ohio, this  
20 22ND day of JUNE, 1998.

21   
22 -----

23 Kris 'A. Adorjan Notary Public/State of Ohio.

24 Commission expiration: 11-30-02.

25

## Look-See Concordance Report

---  
 UNIQUE WORDS: **787**  
 TOTAL OCCURRENCES: **2,666**  
 NOISE WORDS: **384**  
 TOTAL WORDS IN FILE: **8,424**  
 ---

SINGLE FILE CONCORDANCE  
 ---

CASE SENSITIVE  
 ---

COVER PAGES = 4  
 ---

INCLUDES ALL TEXT OCCURRENCES  
 ---

DATES OM  
 ---

INCLUDES PURE NUMBERS  
 ---

POSSESSIVE FORMS ON  
 ---

MAXIMUM TRACKED OCCURRENCE  
 THRESHOLD: **50**

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## Look-See Concordance Report

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UNIQUE WORDS: 787

TOTAL OCCURRENCES: 2,666

NOISE WORDS: 384

TOTAL WORDS IN FILE: 8,424

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SINGLE FILE CONCORDANCE

---

CASE SENSITIVE

---

COVER PAGES = 4

---

INCLUDES ALL TEXT OCCURRENCES

---

DATES ON

---

INCLUDES PURE NUMBERS

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POSSESSIVE FORMS ON

---

MAXIMUM TRACKED OCCURRENCE

THRESHOLD: 50

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