#602

CHE STATE of OHIO,
: SS:
COUNTY of CUYAHOGA.

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IN THE COURT OF COMMON PLEAS

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MONICA DIXON, et cetera,
plaintiffs,

vs. Case No, 324550

UNIVERSITY HOSPITALS
OF CLEVELAND, et al.,
defendants.

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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.

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ON BEHALF OF THE PLAINTIFFS:

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Also present:

Matt Albers

I N D E X

WITNESS: JOHN GRIFFITH, M.D.

NO EXHIBITS MARKED

(FOR COMPLETE INDEX, SEE APPENDIX)

(IF ASCII DISK ORDERED, SEE BACK COVER)

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:

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

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

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

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

Q. Were you involved in that?

A. Yes.

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

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

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

A, Yes.

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

A. I did, for my involvement primarily.

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

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

A. No.

Q. Tell me when your first involvement was.

A. 3-11, 1995.
Q. What was the nature of your involvement on 3-11?
A. Apparently the patient presented to the screening room having contractions every three to five minutes, lasting seconds.
Q. Did you examine her?
A, I did.
Q. How long was she in the screening room?
A, From 2:10 a.m. until 4:30 a.m.
Q. How many times did you see her during that period of time?
A, A minimum of two.
Q. Could you read your notes, please?
A, My notes state that the patient had a nonstress test that showed the fetal heartbeat was 140's to 150's, no contractions were seen, and her cervix was 3 to 4 centimeters dilated.
Q. Is there any information in your notes on that date about her prenatal history?
A. From this date?
Q. Yes.
A. None that I have indicated here,
Q. Would there have been any place in the chart, in the screening room flow sheet on 3-11-95, where

you would have indicated facts about her prenatal history?

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

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

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

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

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

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

A. Yes.

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

A. Yes.

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

A. Yes.

Q. What is the time?

A. 0025.

Q. This is your note, isn't it?
A. Yes.
Q. I take it to mean you examined her on that date?
A. My interpretation of this note is that Dr. Segal examined the patient.
Q. I see a signature line or a signature for you I believe in the lower right-hand corner?
I need you to say yes.
A. Yes. Sorry.
Q. Does that signature indicate that you reviewed this?
A. That I took the patient's history and I obtained all this information, with the exception that I did not examine her when she presented at this time, that another physician did.
Q. How can you tell from looking at this note that Dr. Segal is the one who examined her?
A. I did her physical exam excluding her pelvic exam, but if I don't do the pelvic exam I indicate who the physician was. I put per Segal, M.D.
Q. That is slightly above your signature?
A. Yes.
Q. Whose signature is to the left of yours?
A. Dr. Cynthia Austin.

Q. Did you have any discussions with her at the time that you were recording the information in this note, the OB admit note?
A. I don't recall at the present time. It's our customary practice to let all the people involved in the patient's care know about our patients who are admitted to labor and delivery.
Q. When you let other providers know about the patient, does that include somehow communicating the information that you were writing down on the OB admit note?
A. I'm not sure I understand what you are asking,
Q. It was a bad question probably.

I know that you obtained some information about the patient and you recorded it in the OB admit note, true?
A. Yes.
Q. Did you then communicate that information to Dr. Austin?
A. I don't recall, but that would have been the practice.
Q. So it's likely then that the information that you obtained and recorded on the OB admit note would have been communicated by you to Dr. Austin?

A. I think it's likely, yes.
Q. Is it likely that would have been communicated on the same day, on 3-14-95?
A. I would think so. I think the in-house attending physician and all the residents in the patient's care are aware of each patient who is admitted to labor and delivery.
Q. They would have been made aware on that date?
A. That would be my understanding, yes.
Q. In other words, I am just trying to find out the information you recorded on 3-14-95 on this note, was it communicated to Dr. Austin on that same date?

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

A. I would say it would be based on her signature here,
Q. I was asking you some questions earlier when you were referring to the screening room flow sheet about your awareness of the patient's prenatal care. I want to return to that, but I want you to refer to the OB admit note that you partially prepared.

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

information regarding a glucose tolerance test; do you see that?
A. Yes.
Q. Could you read that, it starts with three, what does that say there?
A. Three hour glucose tolerance test, it's my abbreviation.
Q. What do the numbers signify?
A. Fasting blood sugar, three hours blood sugar, two hours blood sugar, and one hour blood sugar.
Q. Do those values meet the definition of gestational diabetes?
A. Generally gestational diabetes is defined as two abnormal blood sugars.
Q. Are there two here?
A. I'm trying to recall the three hour upper limit of normal, I think there are two abnormals.
Q. Are you certain?
A. No.
Q. In any event, you didn't indicate anywhere on this form that the patient had a gestational diabetic pregnancy, did you?
A. I did not give her that diagnosis. I said in her summary line at the top that she had elevated blood sugars with her pregnancy,

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

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

A. Could you repeat the question?

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

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

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

A. No.

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

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

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

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

testimony anyway.

A. Can you restate your question?

MR. CULLERS: Read the question back.

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

A. My opinion is that she has borderline elevated blood sugars.

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

A, Based on this information, no.

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

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

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

A. Yes.

Q. It is important. All right.

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

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

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

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

Q. Below that fraction?

A. OB history?

Q. Yes. What does that mean?

A, This is her first pregnancy.

Q. What does it mean then below that?

A. OB risks, I put none,

Q. What did that mean?

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

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

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

A. Yes.

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

A. No.

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

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

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

A. No.

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

A. I don't recall,

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

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

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

A. I'm not sure I understand your question.
Q. Did you know what macrosomia was as of 3-14-95?
A. I think so.
Q. Are you sure?
A. Are you asking me based on the chart here or my knowledge?
MR. NORCHI: He is just asking a general question.
Q. 1 just need to know if you knew what macrosomia was as of 3-14-95.
A. Yes.
Q. Did you have an understanding as of 3-14-95 about the obstetrical risks associated with gestational diabetes?
A. Yes.
Q. What were they?
A. That patients who had uncontrolled **blood** sugars could have larger gestational sized infants.
MR. NORCHI: Is that what you wanted, **or** all possibilities? I'm not trying to limit the scope of your questioning.
Q. Well, the nature of my question was what did you understand **to** be the risks associated with gestational diabetes as of 3-14-95, that was my

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

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

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

A, Yes.

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

A. Both,

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

A. A risk for what?

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

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

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

Q. Obviously the word risk means something or at least meant something to you on 3-14-95, true?
A. Yes.
Q. What did it mean to you?
A. A patient with poorly controlled blood sugar could have a large gestational size infant and that could pose risks for delivery.
Q. Now, on your OB admit note, obviously you didn't indicate anything about the fact that a large for gestational age infant was a concern, true?
A, That's correct.
Q. Is there any reason why you didn't indicate that?
A. In looking back on the record it may have been because A, I didn't do her pelvic exam at the time of admission; and B, it was my understanding from her laboratory values that she had well-controlled blood sugars during pregnancy, but had marginal screening tests.
Q. Where did you find the information that she had well-controlled blood sugars?
A. Fasting, two hour blood sugar listed here.
Q. Did you go back to see if her blood sugar levels were well controlled during her prenatal

care?
A. This was during her prenatal care.
Q. Where did you get that information from?
A. From the computer, I would imagine.
Q. So I take it from your testimony that you made a determination, while you were writing the information on the OB note, that there were no obstetrical risks that you had noted that were related to gestational diabetes?
A. Yes.
Q. What other information do you have on here below where it says OB risks, where it says PM?
A. Past medical history, none; past surgical history, she had a breast reduction and an abscess that apparently was drained.
Q. Below that?
A. She stated she was allergic to penicillin, she didn't know the reaction that happened, She took prenatal vitamins, didn't smoke cigarettes, drink alcohol, or use drugs.
Q. If you would *go* down to PE, read that for me.
A. Physical exam: Temperature 37.1; blood pressure **130** over **80**; respiration, 22; her lungs were clear on auscultation. She had a regular rate

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

Q. To the right, what is that?

A. FH, fundal height measurement.

Q. You didn't include that in there?

A. That is correct.

Q. Any reason why?

A. I don't recall.

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

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

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

A, No.

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

A. Positive occasional variable decels,

Q. Right above that?

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

Q. The lower left-hand corner?

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

Q. Below that?
A. Epidural, admit and rupture of membranes.,
Q. What does rupture of membranes mean, it already happened?
A. No, that would be my plan of things to do.
Q. Why did you indicate that as part of your plan?
A. It's a customary procedure to aid in the laboring process,
Q. When I was asking you earlier about your understanding of obstetrical risks that may be associated with gestational diabetes, you said something about a large for gestational age fetus; do you recall that?
A. Yes.
Q. What is it about that fact, a large for gestational age fetus, that yields a risk?
A, The risks are primarily associated with delivery through the birth canal and glucose, fetal glucose management after delivery.
Q. What risks are associated with the delivery for a large gestational age infant through the birth canal?
A, Arrest of active phase of labor, and difficulties in delivering the fetus.

Q. Are these things that you were aware of as of 3-14-95?
A. Yes.
Q. Tell me as of 3-14-95 your level of experience.
A. In what?
Q. Were you a first year resident?
A. Yes. Level of experience in what?
Q. That's what I meant. I just wanted to know what your position was or title,

How many labor and deliveries had you been involved in as of 3-14-95?
A. I don't know for sure, probably around 150.
Q. I want to focus on an aspect of what your customary practice was as of **3-14-95.**

When you are admitting a patient you are preparing a note such as your OB admit note here, and you are inquiring about the patient's prenatal care; do you obtain a copy of the chart from her prenatal care?
A. Yes.
Q. Is that something that you get, that you have in hand at the time you are writing down the information that you take down when you admit a patient?

A. Generally, yes.
Q. Where does that come from, where is that kept?
A. On labor and delivery.
Q. So it's not something that is difficult to obtain?
A. Generally, no,
Q. It certainly wasn't uncommon as of 3-14-95, you were able to have it actually when you are writing down information about the patient?
A. I don't recall whether I had a copy of her chart or whether this was the information she presented to me,
Q. What was your usual practice back then on 3-14-59, to actually have a copy of the chart?
A. Absolutely, if it was available.
Q. If it was available the likelihood is you had it with you when you wrote this information down on the OB admit note?
A. Yes.
Q. It is likely some of the information about her history you obtained from that chart?
A, Yes, if it was available.
Q. Would you feel uncomfortable not having it?
A. I'm not sure how to answer that,

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

A. I would prefer her chart, yes.

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

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

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

Q. That was your progress note?

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

Q. Up until when?

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

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

A. No.

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

have recorded at 2:10 a.m.?
A. Yes. Patient without complaints, epidural in place. I listed her vital signs, her cervical dilation, and her nonstress test, and then I artificially ruptured her membranes at 2:10 a.m. for thick meconium stained fluid.
Q. So you actually did a vaginal exam at 2:10?
A. Yes.
Q. That's when you arrived at the value you indicated for station?
A. Yes, that's my exam.
Q. And for dilatation also?
A. Yes.
Q. Did you do a vaginal exam when you were preparing the information contained in your: admit note?
A. No, Dr. Segal did.
Q. Do you know whether station has changed between his vaginal exam and then yours at 2:10 a.m.?
A. I can't say because I didn't examine her, but the notation is different.
Q. The notation seems to indicate a high station?
A. Correct.

Q. What does that mean?
A. I don't know, I don't know what Dr. Segal meant by that,
Q. If you would have reviewed that chart or that note on 3-14-95, what would you have understood that to mean?
A. That the station was probably greater than minus 2.
Q. Greater than minus 2; is that what you said?
A. Yes.
Q. When you are determining station, how do you do that? Or I should ask it this way: When you were determining station on 3-14-95 at 2:10 a.m., how did you do it?
A. I performed a pelvic exam and assessed the presenting part of the fetus and internal bone pelvis.
Q. What is the presenting part of the fetus?
A. Vertex -- I'm not sure I understand your question.
Q. You have to find the relationship of the presenting part of the fetus with the ischial spines of the mother, true?
A. Yes.
Q. What is the presenting part that you are

looking for on the fetus?
A. You want the medical term?
Q. Yes.
A. The biparietal diameter,
Q. Where is it? Show me.
A. Right here,
Q. You can feel that with your hand?
A. Yes.
Q. Can you go down to your next note at 3:45 a.m.?
A. Painful contractions, listed the patient's vital signs, her cervical exam, and her nonstress test.
Q. Her cervical exam, she is 5 centimeters dilated?
A. Yes.
Q. She is having painful contractions; is that what you said?
A. Yes,
Q. Is she in active labor at 3:45 a.m.?
A, No.
Q. How do you know that?
A. I'm not sure if she is in labor at all.
Q. What would you need to see to feel confident in determining that she was in active labor?

A. I would need to see adequate contractions and cervical change.
Q. You mean you needed to see cervical change beyond the 5 centimeters of dilatation that you see at 3:45 a.m.?
A. Yes, combined with contractions.
Q. How can you tell by looking at your note at 3:45 a.m. that she wasn't having forceful contractions to meet the definition of active labor?
A. At 3:45 she didn't have an internal pressure catheter. She did not have an internal pressure catheter in place.
Q. There was no way to measure the force of the contractions?
A. No.
Q. That doesn't mean there wasn't a forceful contraction?
A. I don't know, it could have been.
Q. You just don't know because it wasn't measured?
A. I can't say. It could have been.
Q. If it would have been sufficiently forceful as of 3:45, the fact that she was 5 centimeters dilated in conjunction with forceful contractions,

would that meet the definition of labor?
A. Restate that, please.
Q. If she was having sufficiently forceful contractions at 3:45 a.m., and she was 5 centimeters dilated that would meet the definition of labor?
A. I define labor as cervical change at the time with adequacy of contraction,
Q. Over what period of time for cervical change?
A. Generally that's in a period of two hours,
Q. You said that you continued to be involved with Dr. Segal after caring for this patient at 3:45; you said that earlier?
A. I believe *so.* I don't have further notes in the patient's chart, but that was the customary practice.
Q. That's what I want to find out.

Why is it that you may be involved after 3:45 a.m.?
A. Because Dr. Segal and myself were the two residents on labor and delivery that evening.
Q. Is there any way you can tell by looking at Dr. Segal's note of 5:15 a.m. whether the patient is in active labor?
A. She would appear to be because she had

cervical change.

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

A. Yes,

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

A. No,

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

A. No.

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

A. No.

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

A. No.

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

A. Based on my customary practice, yes.

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

A. Yes, he was my senior resident.

Q. Would he have been a third year resident?

A. Second year.
Q. Would you have had any discussions with Dr. Austin during your involvement with this patient?
A. Did I or would 1 have?
Q. Well, do you recall any?
A. No.
Q. Consistent with the normal practice would you have had any discussions with her?
A, The normal practice is to make sure that the two residents on labor and delivery, the chief resident and the attending physician, all know about the patient.
Q. How does that happen, are there specific times when Dr. Austin would have discussions with you?
A. Assigned times?
Q. Yes.
A. No.
Q. How would it generally work?
A, Just by word-of-mouth on labor and delivery.
Q. Could you turn to the consent for treatment form; that contains your signature?
A. That's a question?
Q. Yes.

A. Yes.
Q. Is this something that you filled out?
A. Yes.
Q. Do you recall doing this?
A. No.
Q. Do you recall what your normal practice was when you filled out one of these back in March of 1995?
A. Yes.
Q. Tell me how you went about doing that with a patient.
A. I would tell the patient that she is being admitted to labor and delivery for our plan of labor, vaginal delivery, and that there is always the possibility of a Cesarean section.

If she requires anesthesia this would be a consent form that would include that, and that we never anticipate the use of blood products, but were they to be necessary this would be included on your consent.
Q. That's what you do, explain that to her, show her this form?
A. Yes.
Q. Did you read this whole thing to her?
A. No, I let the patient read it.

Q. Did you have any discussions with her about any potential risks associated with the fact that the child ma'y be a large for gestational age fetus?
A. Can you restate the question?
Q. Was there any discussion about any suspicion that you may have had that the patient or that the fetus was a large for gestational age fetus?
A. Let me rephrase your question. I'm not sure I understand it,

Did I discuss with the patient whether her fetus was large for gestational age?
Q. Yes. Did you discuss that with her?
A. No.
Q. Is it because you didn't think that was the case?
A. Yes.
Q. When you explained the procedure of a vaginal delivery, was there any discussion at all about complications that might arise as a result of the baby being a large for gestational age baby?
A. No.
Q. You remember that to be the case?
A. No, that's not something 1 customarily include in my admission consent form discussion,
Q. In this particular instance, based on the

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

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

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

A, No, not that I can tell,

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

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

MR. CULLERS: Off the record.

(Discussion had off the record,)

BY MR. CULLERS:

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

A. No, probably not,

Q. Why do you reach that conclusion?

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

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

A. There are potential risks to a diabetic pregnancy.

MR. NORCHI: How about in this particular patient?

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

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

a gestational diabetic pregnancy, true?

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

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

A. Okay.

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

A. That is correct,

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

MR. NORCHI: That's the theoretical question.

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

Q. Why not?

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

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

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

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

MR. **NORCHI:** Objection. Asked and answered. You can answer it again.

A. State the question again,

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

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

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

of these providers about gestational diabetes?
A. I'm not sure that I know what you're asking.
Q. I'm asking based on your review of the information here, is it likely you had a discussion with any of the providers that this lady may have had a gestational diabetic pregnancy?
A. I would say that is likely.
Q. When is it likely that such discussions would have occurred?
A. Probably after I summarized -- after her admission, history, and physical information.
Q. Would that have been on 3-14-95?
A. Yes.
Q. Would that have been before the delivery of the baby?
A. Yes.
Q. Without trying to pinpoint you to exactly when you would have done that, would it have been simultaneously or spontaneously with your preparation of the information contained in the OB note?
A. I would think that would be reasonable to conclude that.
Q. So that's when any such discussions would have occurred about gestational diabetes?

A. Yes.
Q. Do you recall having any discussions with any of Monica Dixon's providers about whether a C-section may be appropriate?
A. No.
Q. Do you know anything about the delivery itself?
A. I briefly reviewed the note from Dr. Krietsky.
Q. What do you recall about it?
MR. NORCHI: You can turn to it.
A. It was a vacuum assisted delivery, with the delivery of a 4137 gram infant.
Q. You weren't involved in any way in the actual details of the delivery, were you?
A, No.
Q. Did you have any discussions with Dr. Krietsky about the details of the delivery at any point?
A. No.
Q. Not even afterward?
A. No.
Q. Do you recall having any discussions with any of the providers about abnormal progress of labor

with this patient?
A. Again, I can only answer what my practice would be because my discussions aren't indicated in the chart.
Q. What would that be?
A. To discuss the patient's cervical exam with Dr. Segal.
Q. During the time frame that you believe you may have been involved with Dr. Segal after 3:45 a.m., is there anything in the notes that causes you to believe that you may have had a discussion with him about the abnormal progress of labor with this patient?
A. I'm not sure that I know what you are asking.
Q. Can you turn to the progress of labor chart? It's back with the labor notes in my chart, the copy of the chart I have, It looks like this. There it is.

We know the last note occurred at 3:45 a.m.; is that right?
A. Yes.
Q. You continued to be involved. You set up until perhaps 7:00 a.m. when there was a shift change?
A. Yes, that was my shift.

Q. If you look at the progress of labor chart you would agree with me, wouldn't you, that station at least as it's charted didn't change between approximately 2:50 a.m. and seven o'clock a.m.?
A. Station or dilation?
Q. Station, it's the X's.
A. Are you asking me to interpret this chart or --
Q. No. The question was: Did station change between approximately 2:50 a.m. and seven o'clock a.m., at least as it's charted here on the progress of labor chart?
A. As it's charted here it stayed the same, Dr. Segal's note, plus 1 station at 7:00 a.m.
Q. During that period of time between approximately 2:50 a.m. and seven o'clock a.m., is it likely that you would have had a discussion with Dr. Segal about the progress of labor?
A. Yes, because I placed internal monitors.
Q. What time did you do that?
A. 3:45.
Q. Is it likely that at some point between 2:50 a.m. and seven o'clock a.m. that you would have had a discussion with Dr. Segal about the fact that there may be abnormal progress of labor?

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

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

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

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

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

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

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

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

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

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

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

A. No.

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

A. No, not that 1 recall.

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

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

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

A. Yes.

Q. Why would that have been something that the two of you discussed?
A. We would both be on the same page in terms of her dilation and descent.
Q. Why would the fact that the descent didn't change for a period of several hours be of significance to you and Dr. Segal?
A, I'm not sure how much significance it was. I think it's part of the whole picture of labor,
Q. Did it have any significance at all to you?
A. It's a requirement for delivery.
Q. I guess I don't understand that answer,
A, You have to completely dilate and descend the fetal head.
Q. Before the baby can deliver?
A. Yes.
Q. If station doesn't change for four hours, does that fact that it hasn't changed cause any concern to you?
A. No, I don't think the patient is in labor,
Q. When do you think that active labor began?
A. Sometime between 3:45 and 5:15.
Q. Does the fact that station doesn't change at least according to the vaginal exams and the progress of labor chart between 5:00 and 7:00 a.m.

cause any concern to you?
A. It does appear to change, it goes from 0 to plus 1.
Q. Are you talking about Dr. Segal's progress note?
A. Yes.
Q. At seven o'clock a.m.?
A. Yes.
Q. Will you look at Dr. Krietsky's note of eight o'clock?
A. Yes.
Q. If you have read the information regarding her vaginal exam on 3-14-95, what would you have understood station to have meant?
A. By her exam that was between 0 and plus 1.
Q. Somewhere between 0 and plus 1?
A. Yes.
Q. Is it fair to say that station had changed less than 1 centimeter between five o'clock a.m. and eight o'clock a.m.?
A. Somewhere around there, it's a subjective exam.
Q. Does the fact that it changed only that much cause any concern?
A. I think it's combined with the change in her

cervical dilatation.
Q. So it doesn't cause concern?
A. It causes some concern but it's weighed with her change in cervical dilation and the overall progress.
Q. What is the concern caused by the fact that station changes only about a centimeter during a three hour or four hour period?
A. Generally, the period of most rapid descent is somewhere after 7, 8 centimeters. I don't know if it causes a lot of concern, but it poses some.
Q. The fact that it poses some concern, why does it cause some concern; what is it about that fact that causes some concern?
A, Because the fetal head has to descend into the maternal pelvis in order to deliver.
Q. The fact that it hasn't descended faster than that indicates something that is a negative?
A. What do you mean by "negative"?
Q. You said it causes some concern in response to my question what is the significance of the fact that the station changes 1 centimeter over a three, four hour period of time. I'm trying to figure out why you said it causes some concern. The fact that it doesn't change, why does that cause concern?

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

Q. In terms of this labor and delivery.

A. I'm not sure how to answer.

Q. Because of the question or --

A. Yes.

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

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

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

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

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

the descent of the fetal head.

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

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

Q. No, No.

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

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

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

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

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

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

Q. I noticed that you reviewed the operative

report just then when you were answering the question.

A. Yes.

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

A. Yes.

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

A, Yes.

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

MR. NORCHI: By Dr. Krietsky?

MR. CULLERS: By anyone.

Q. Do you know?

A. No.

Q. Do you believe that this infant was macrosomic?

A. No.

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

A. It could have.

Q. How does that happen?

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

variable in descent of the fetus through the maternal pelvis.

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

A. Yes.

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

MR. NORCHI: Objection.

A. No.

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

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

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

A. Can you rephrase that?

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

That was a pretty bad question. Let me try to ask it in a more articulate way, if I

can.

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

A. Based on my notes, no.

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

A. About the size of the fetus?

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

A. No.

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

A. When?

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

A. That's not part of this.

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

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

A. This is from 3-11.

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

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

A. Can I see it?

Q. Sure.

A. It was to check for amniotic fluid volume,

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

A. No.

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

Q. Where did you *go* to medical school?

A. Here, Case Western Reserve,

Q. You graduated in?

A. 1994.

Q. This is your fourth year of residency?

A. Yes.

Q. You have one after that?

A. No,

Q. This is it?

A, Yes.

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

THE WITNESS: Yes.

Q. Just finished?

A. Yes.
Q. Where do you plan to practice?
A. Geauga County.
Q. Is there a practice group that you are going to join?
A. Yes.
Q. What is the name of it?
A. University Primary Care Physicians. I don't know beyond that.
Q. Have you ever been involved in any situation where you have ever been involved in any litigation?
A. No.
Q. Have you ever been involved in the management of labor and delivery of a child where the child had a resulting Erb's palsy?
A. No.
Q. Have you ever been deposed before?
A. No.

MR. CULLERS: That's it. Thank you.

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

(Deposition concluded; signature not waived.)

ERRATA SHEET

NOTATION	PAGE/LINE

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

_____

JOHN GRIFFITH, M.D.

The State of Ohio, .
County of Cuyahoga. CERTIFICATE:

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

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

Kris Adorjan

Kris 'A. Adorjan Notary Public/State **of** Ohio.
Commission expiration: 11-30-02.

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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

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