

In The Matter Of:

*MCSELFISH v.
MERIDIA MEDICAL*

*STEVEN INGLIS
February 17, 2005*

*FINK & CARNEY REPORTING AND VIDEO SERVICES
39 WEST 37TH STREET
NEW YORK, NY USA 10018
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[1]
[2] IN THE COURT OF COMMON PLEAS
STATE OF OHIO
[3] COUNTY OF CUYAHOGA
[4]
KARL McELFISH, II, Admin., etc.,
[5]
Plaintiff,
[6] Case No.
-against- 465040
[7]
MERIDIA MEDICAL GROUP, et al.,
[8]
Defendants.
[9]
[10]
[11] February 17, 2005
2:18 p.m.
[12]
[13]
[14] Deposition of STEVEN R. INGLIS, M.D., taken by
[15] Defendants, at the office of Fink & Carney, 39
[16] West 37th Street, New York, New York, before
[17] Linda A. Marino, Registered Professional
[18] Reporter, Certified Shorthand Reporter, and
[19] Notary Public within and for the State of New
[20] York.
[21]
[22]
[23]
[24]
[25]

[1]
[2] Appearances:
[3]
[4] BECKER & MISHKIND CO., L.P.A.
Attorneys for Plaintiffs
[5] 134 Middle Avenue
Elyria, Ohio 44035
[6]
BY: MICHAEL F. BECKER, ESQ.
[7]
-AND-
[8]
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[9] 250 Spectrum Office Building
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Independence, Ohio 44131-7300
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BY: GEORGE E. LOUCAS, ESQ.
[11]
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[13] GALLAGHER SHARP FULTON & NORMAN
Attorneys for Defendant
[14] Lucille Stine, M.D.
Seventh Floor, Bulkley Building
[15] 1501 Euclid Avenue
Cleveland, Ohio 44115
[16]
BY: ERNEST W. AUCIELLO, JR., ESQ.
[17]
[18]
MOSCARINO & TREU, L.L.P.
[19] Attorneys for Defendant
Charles M. Ballin, M.D.
[20] 630 Hanna Building
1422 Euclid Avenue
[21] Cleveland, Ohio 44115
[22] BY: KRIS TREU, ESQ.
(via videoconference)
[23]
[24]
(continued on next page)
[25]

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[1]
[2] Appearances(continued):
[3]
[4] REMINGER & REMINGER
[5] Attorneys for Defendants
[6] Meridia Medical Group, Gregory
[7] Karasik, M.D., and Yelena
[8] Beregovskaya, R.N.
[9] 1400 Midland Building
[10] 101 Prospect Avenue, West
[11] Cleveland, Ohio 44115-1093
[12]
[13] BY: MARILENA DiSALVIO, ESQ.
[14] STEPHEN E. WALTERS, ESQ.
[15] (via videoconference)
[16]
[17]
[18] REMINGER & REMINGER
[19] Attorneys for Defendant
[20] Meridia Euclid Hospital
[21] 1400 Midland Building
[22] 101 Prospect Avenue, West
[23] Cleveland, Ohio 44115-1093
[24] BY: CHRISTINE S. REID, ESQ.
[25] (via videoconference)

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[1] **S. R. INGLIS**
[2] (Prior to the start of the
[3] deposition, Curriculum vitae was marked
[4] Exhibit 1 for identification; and
[5] 6/7/04 Report was marked Exhibit
[6] 2 for identification.)
[7]
[8] STEVEN R. INGLIS, having
[9] been first duly sworn by a Notary Public
[10] of the State of New York (Linda A.
[11] Marino), was examined and testified as
[12] follows:
[13] **EXAMINATION**
[14] **BY MR. AUCIELLO:**
[15] **Q:** Would you please state your name
[16] for the record, please?
[17] **A:** Steven Inglis.
[18] **Q:** Doctor, have you ever been
[19] deposed before?
[20] **A:** Yes.
[21] **Q:** About how many times?
[22] **A:** Two times.
[23] **Q:** I'll go over some of the ground
[24] rules.
[25] It's basically simple. This is

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[1] **S. R. INGLIS**
[2] just a question-and-answer session under
[3] oath. I am taking your deposition, as are the
[4] other attorneys by videoconferencing, because
[5] you've been identified as an expert for the
[6] Plaintiff in this case.
[7] If you don't understand any
[8] question I ask you, I would ask that you tell
[9] me that so I can rephrase it. Otherwise, I'll
[10] end up assuming that you understood the
[11] question.
[12] Is that fair?
[13] **A:** Yes.
[14] **Q:** It's also important so we have an
[15] accurate record that you give verbal responses
[16] to all my questions, as opposed to nods of the
[17] head or nonverbal signals because the court
[18] reporter can't take those down.
[19] Fair?
[20] **A:** Yes.
[21] **Q:** Doctor, I will ask you under what
[22] circumstances were you deposed those two other
[23] times?
[24] **A:** I believe I've been deposed twice
[25] as an expert witness.

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[1] **S. R. INGLIS**
[2] **Q:** As an expert.
[3] When was the last time you were
[4] deposed?
[5] **A:** Probably two years ago.
[6] **Q:** Do you remember the name of the
[7] case?
[8] **A:** I do not.
[9] **Q:** Do you remember where that case
[10] was situated?
[11] **A:** New York.
[12] **Q:** In New York.
[13] Do you remember who you were a
[14] witness for?
[15] **A:** No.
[16] **Q:** Do you remember the general
[17] subject matter of that case?
[18] **A:** I do not.
[19] **Q:** What about the other deposition?
[20] **A:** That deposition was many years
[21] ago.
[22] **Q:** Were you also an expert in that
[23] case?
[24] **A:** Yes.
[25] **Q:** Do you remember the name of that

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[1] **S. R. INGLIS**
[2] case?
[3] **A:** Do not.
[4] **Q:** Do you remember the general
[5] subject matter of that case?
[6] **A:** Shoulder dystocia.
[7] **MR. TREU:** Ernie, excuse me.
[8] Can you keep your voice up?
[9] I'm having a hard time hearing
[10] you.
[11] **MR. AUCIELLO:** All right.
[12] **Q:** That was a shoulder dystocia
[13] case, the one you were involved in many years
[14] ago?
[15] **A:** Yes.
[16] **Q:** Do you remember if you were
[17] expert for the plaintiff or the defendant?
[18] **A:** Plaintiff.
[19] **Q:** Are those the only two
[20] depositions you've given in your life?
[21] **A:** I'm not sure of the definition of
[22] deposition. I've certainly been as a witness
[23] to cases and things like that, but I think —
[24] is that a deposition?
[25] **Q:** Any time that you've given

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[1] **S. R. INGLIS**
[2] testimony under oath in front of a court
[3] reporter.
[4] **A:** Oh, then it's more than that.
[5] **Q:** About how many times?
[6] **A:** Probably four, total.
[7] **Q:** Tell me about the other two that
[8] we haven't talked about.
[9] **A:** One of them was a case where I
[10] was not named but a witness, and they wanted
[11] me to come in and help.
[12] **Q:** You were a fact witness in a
[13] medical malpractice case?
[14] **A:** Correct.
[15] **Q:** And what about the fourth one?
[16] **A:** I'm just guessing there must be
[17] one other time I've been.
[18] **Q:** Have you ever been named a
[19] defendant in a medical negligence case?
[20] **A:** Yes.
[21] **Q:** Were you deposed in that case?
[22] **A:** No.
[23] **Q:** And what happened with that case?
[24] **A:** I was dropped out of it.
[25] **Q:** Do you remember the subject

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[1] **S. R. INGLIS**
[2] matter of that case?
[3] **A:** Fetal distress.
[4] **Q:** And you were dismissed without
[5] payment?
[6] **A:** Correct.
[7] **Q:** And that was here in New York?
[8] **A:** Yes.
[9] **Q:** Doctor, what's your present
[10] professional address?
[11] **A:** St. Barnabas Hospital, 4422 Third
[12] Avenue, Bronx, New York.
[13] **Q:** And who is your employer?
[14] **A:** St. Barnabas Ob-Gyn, P.C.
[15] **Q:** So, you work for a physician
[16] group?
[17] **A:** I run the physician group.
[18] **Q:** You're president of that
[19] organization?
[20] **A:** Yes.
[21] **Q:** Do you have any employment other
[22] than your employment with that organization?
[23] **A:** No.
[24] **Q:** How long have you been with St.
[25] Barnabas — the St. Barnabas organization

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[1] *S. R. INGLIS*
[2] you've mentioned?
[3] **A:** Eight years.
[4] **Q:** I've directed to be put before
[5] you your CV and a report. I don't know which
[6] is — the CV is marked as Exhibit 1.
[7] Is that a true and accurate copy
[8] of your curriculum vitae?
[9] **A:** Yes.
[10] **Q:** Is it reasonably up to date?
[11] **A:** Yes.
[12] **Q:** And Exhibit 2, is that a true and
[13] accurate copy of the written report you
[14] provided to Mr. Becker concerning this case?
[15] **A:** As far as I can see, yes, it
[16] looks like the same thing, yes.
[17] **Q:** Did you do any other reports,
[18] other than that one?
[19] **A:** No.
[20] **Q:** Okay.
[21] Doctor, at what hospitals do you
[22] presently have privileges?
[23] **A:** St. Barnabas Hospital and New
[24] York Presbyterian-Cornell.
[25] **Q:** How would you describe the nature

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[1] *S. R. INGLIS*
[2] of your practice?
[3] **A:** It is obstetrics, gynecology, and
[4] high risk obstetrics.
[5] **Q:** Can you give me a breakdown
[6] between obstetrics and gynecology?
[7] Is it 50/50? 60/40?
[8] **A:** Obstetrics would be 90 percent
[9] for me.
[10] **Q:** Okay.
[11] Other members of your group may
[12] differ?
[13] (Whereupon, Ms. Reid, Mr.
[14] Walters, and Ms. DiSalvio joined the
[15] videoconference.)
[16] **MR. TREU:** Hold on.
[17] We have new attendees.
[18] (Pause in proceedings).
[19] **Q:** Doctor, I think you just told us
[20] your practice is 90 percent obstetrics and 10
[21] percent gynecology?
[22] **A:** Yes.
[23] **Q:** And the others in your group may
[24] vary?
[25] **A:** Generally 50 percent for the rest

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[1] *S. R. INGLIS*
[2] of the group.
[3] **Q:** Do you have a subspecialty?
[4] **A:** I am a maternal-fetal medicine
[5] specialist.
[6] **Q:** Any particular area of interest
[7] within maternal-fetal medicine?
[8] **A:** Preterm delivery.
[9] **Q:** Is it true that the major thrust
[10] of your research has been the cause of preterm
[11] delivery?
[12] **A:** Yes.
[13] **Q:** Doctor, directing your attention
[14] to the curriculum vitae, it lists a number of
[15] publications.
[16] I don't want to go through them
[17] all, but can you identify for us any of the
[18] publications you have in that CV that may be
[19] relevant to the issues in this case?
[20] **A:** One that may be possibly relevant
[21] would be — doesn't have a number next to it
[22] — the article that was entitled: When should
[23] twins be delivered?
[24] **Q:** Okay.
[25] **A:** That's it.

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[1] *S. R. INGLIS*
[2] **Q:** So I don't forget to come back to
[3] it, what about that article that is entitled:
[4] When should twins be delivered?, what about
[5] that article makes it relevant to this case?
[6] **A:** Well, I think in that article you
[7] will be able to see that part of our job is to
[8] determine when is the best time to deliver
[9] twins. And it's not any different than any
[10] patient who has blood pressure problems in
[11] pregnancy. It's the same issue of concern and
[12] the thought process that needs to go into the
[13] decision as to when those babies should be
[14] delivered, and twins.
[15] **Q:** Regardless of when — it applies
[16] when there's not twins as well?
[17] **A:** Correct.
[18] **Q:** Doctor, do you have any present
[19] teaching responsibilities?
[20] **A:** Yes.
[21] I teach medical students and
[22] residents at St. Barnabas Hospital, and I
[23] teach residents at Cornell as well.
[24] **Q:** Do you have a title at Cornell?
[25] **A:** I'm an associate professor of

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[1] **S. R. INGLIS**
[2] obstetrics and gynecology.
[3] **Q:** Do you have any administrative
[4] roles at either the hospital or the
[5] university?
[6] **A:** No administrative role at the
[7] university.
[8] At St. Barnabas Hospital, I'm in
[9] charge of the department of Ob-Gyn and
[10] basically take care of a big department of
[11] Ob-Gyns and midwives, and, to a certain
[12] extent, have to monitor the nursing as well
[13] inside of the hospital.
[14] **Q:** About what percentage of your
[15] professional time is consumed by the
[16] administrative role you have to have at the
[17] hospital?
[18] **A:** I would say fifteen percent is
[19] administrative.
[20] **Q:** You also have — you're president
[21] of your practice, your own practice, the St.
[22] Barnabas group?
[23] **A:** Yes.
[24] **Q:** How much of your time is occupied
[25] by that job?

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[1] **S. R. INGLIS**
[2] **A:** I'm including that in the fifteen
[3] percent.
[4] **Q:** Other than teaching students at
[5] Cornell and St. Barnabas and your practice at
[6] St. Barnabas and New York Presbyterian through
[7] your company, is that the entirety of your
[8] medical practice right now?
[9] **A:** Yes.
[10] **Q:** And how long has it been
[11] substantially the same?
[12] **A:** For eight years.
[13] **Q:** Eight years?
[14] **A:** Yeah.
[15] **Q:** You haven't had privileges at
[16] different hospitals, it's all been the same?
[17] **A:** I did have privileges at another
[18] hospital in the Bronx for a while. And then
[19] our hospital decided I should not continue
[20] those privileges and was basically —
[21] basically, the hospital is no longer working
[22] as well with that other hospital and basically
[23] told me to drop my privileges with that other
[24] hospital.
[25] **Q:** You voluntarily dropped your

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[1] **S. R. INGLIS**
[2] privileges there?
[3] **A:** Yes.
[4] I was basically coverage for
[5] their emergency room. They don't do
[6] deliveries there.
[7] **Q:** What's the name of that hospital?
[8] **A:** Westchester Square, some
[9] modification of that name.
[10] (Whereupon, Mr. Loucas exited the
[11] deposition.)
[12] **Q:** Could you hand me the exhibits
[13] back? I, unfortunately, don't have copies.
[14] You went to medical school at New
[15] York Medical College from 1982 to 1986?
[16] **A:** Yes.
[17] **Q:** And tell us about your medical
[18] training after medical school.
[19] **A:** After medical school, I went up
[20] to Albany Medical Center and spent four years
[21] doing a general Ob-Gyn residency.
[22] And then when I finished that, I
[23] applied for fellowship and came down to
[24] Cornell and spent two years in the
[25] maternal-fetal medicine fellowship there.

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[1] **S. R. INGLIS**
[2] And then — you want me to just
[3] continue?
[4] **Q:** Sure.
[5] **A:** And then when the fellowship
[6] ended, I took over a contract to do all of the
[7] maternal-fetal medicine at Jersey City Medical
[8] Center, which is a hospital just across the
[9] Hudson River in Jersey City, and did all their
[10] maternal-fetal medicine and also worked two
[11] days a week at Cornell.
[12] And that continued basically like
[13] that until 1997, when I moved up and took over
[14] — I was the chief of Ob-Gyn at Lincoln
[15] Hospital and at St. Barnabas Hospital at the
[16] same time.
[17] And then — and then eventually
[18] St. Barnabas separated from Lincoln Hospital,
[19] so I stayed on as chief of Ob-Gyn at St.
[20] Barnabas Hospital, and that's where I am
[21] today.
[22] **Q:** Doctor, I ask these in all
[23] depositions, but have your privileges ever
[24] been suspended or revoked?
[25] **A:** No.

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S. R. INGLIS

[1] **Q:** You're licensed to practice only
[2] in New York and New Jersey?
[3] **A:** Correct.
[4] I don't think I'm licensed right
[5] now to practice in New Jersey. I think I
[6] stopped paying.
[7] **Q:** Stopped paying the dues?
[8] **A:** Yeah.
[9] **Q:** Have you ever been licensed
[10] anywhere else?
[11] **A:** No.
[12] **Q:** Has your license to practice
[13] medicine ever been suspended or placed under
[14] investigation?
[15] **A:** No.
[16] **Q:** Doctor, if there were — is there
[17] a textbook that you would state would be the
[18] best one for a person to learn about the
[19] general principals of obstetrics and
[20] gynecology?
[21] **A:** No.
[22] **Q:** I think — is there one used in
[23] your teaching?
[24] **A:** To be honest, I would suggest

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S. R. INGLIS

[1] that there are so many books available it's
[2] hard to pin down. I mean, there are titles
[3] that are considered the, you know, most
[4] important, but I'm actually not so sure
[5] whether — I've been doing this for a while
[6] now — whether those titles are that much
[7] better than other titles in terms of the
[8] specifics.
[9] **Q:** What are the preeminent titles?
[10] **A:** Williams Obstetrics,
[11] Maternal-Fetal Medicine by Creasy.
[12] But there's many others who are
[13] maybe just as good and could be better.
[14] **Q:** Okay.
[15] As to the Williams textbook or
[16] the Creasy textbook, do you consider them
[17] reliable?
[18] **A:** I think they all have their
[19] biases because they're written by people who
[20] automatically have biases.
[21] So, I'm not sure I can answer the
[22] question.
[23] **Q:** If I'm understanding you, no
[24] textbook, as opposed to peer-reviewed

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S. R. INGLIS

[1] articles, would you consider to be reliable.
[2] **A:** Correct.
[3] **Q:** Doctor, when did you first become
[4] involved in this case?
[5] **A:** I received a phone call from — I
[6] think it was Mr. Becker, and I don't even know
[7] how many years ago that was, and he asked me
[8] to look at the case.
[9] **Q:** Had you ever worked for Mr.
[10] Becker before?
[11] **A:** No.
[12] **Q:** Do you advertise your services as
[13] expert consultant?
[14] **A:** No.
[15] **Q:** Do you know how Mr. Becker found
[16] you?
[17] **A:** No.
[18] **Q:** Are you listed on any referral
[19] format through the internet or any
[20] organizations who connect lawyers that need
[21] expertise with experts?
[22] **A:** No.
[23] **Q:** And I take it that any billing
[24] arrangements for your time are directly

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S. R. INGLIS

[1] between you and Mr. Becker's office.
[2] **A:** Yes.
[3] **Q:** How much are you charging us for
[4] the deposition today?
[5] **A:** I don't know.
[6] **Q:** Okay.
[7] Do you have an hourly rate you're
[8] charging Mr. Becker?
[9] **A:** I've not discussed it with him in
[10] any detail.
[11] **Q:** How often do you review cases for
[12] lawyers?
[13] **A:** Probably one a year or maybe less
[14] than that.
[15] **Q:** How long have you been doing
[16] that?
[17] **A:** Since I started my fellowship.
[18] My mentor couldn't handle some
[19] case, so he gave me the case. And then I did
[20] it once in a while from then.
[21] **Q:** Do you have a breakdown of how
[22] often you're retained by the attorney for the
[23] patient as opposed to the attorney for the
[24] doctor or the hospital?

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[1] **S. R. INGLIS**
[2] **A:** The vast majority are patient.
[3] **Q:** Do you know why?
[4] **A:** I have no idea why.
[5] **Q:** Do you serve — other than in
[6] medical negligence cases, do you do medical
[7] legal consulting in any other area?
[8] **A:** No.
[9] **Q:** And do you know when the phone
[10] call was from Mr. Becker that first involved
[11] you in this case?
[12] **A:** I do not, no.
[13] **Q:** What have you reviewed in this
[14] case to reach your opinions?
[15] **A:** In my report, it has a clear list
[16] of exactly what I have reviewed. And the only
[17] other thing that I've reviewed, which I just
[18] received recently, were a few of the expert
[19] reports.
[20] **Q:** Just so the record is clear, we
[21] have the twelve items listed in your report,
[22] then there are additional items of certain
[23] expert reports.
[24] Can you tell us which expert
[25] reports you have reviewed?

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[1] **S. R. INGLIS**
[2] **THE WITNESS:** Do we have a book?
[3] There was a book you gave me last
[4] night. I think it was here, and he may
[5] have taken it away.
[6] **A:** I think it's an up-to-date list
[7] of all of the reports of whatever has been
[8] done in terms of expert reports. I think I've
[9] done every one.
[10] **Q:** Did you see a Dr. Bick's report?
[11] **A:** Yes.
[12] **Q:** Do you see Dr. Raymond Redline's
[13] report, the pathologist for the Plaintiff?
[14] **A:** Yes.
[15] **Q:** Have you seen doctor — let me
[16] see, Dr. Flam's report for the defense?
[17] **A:** I'm not sure, what does he do?
[18] **Q:** Obstetrics.
[19] **A:** I don't think so, no.
[20] I may not have seen them all,
[21] because I'm pretty sure I did not see Dr.
[22] Flam.
[23] We really should get the other
[24] book I got last night.
[25] **Q:** Do you recall a Dr. Floyd's

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[1] **S. R. INGLIS**
[2] report?
[3] **A:** What does he do?
[4] **Q:** OB.
[5] **A:** I don't think I saw that either.
[6] **Q:** Zabuy, Dr. Zabuy?
[7] **A:** I saw Zabuy.
[8] **Q:** You saw Zabuy.
[9] Dr. Baggans, hematology?
[10] **A:** I'm not sure.
[11] **Q:** Dr. Essig, I guess this is a
[12] nursing expert.
[13] Dr. Essig?
[14] **A:** I don't think so, no.
[15] **Q:** So it would appear you haven't
[16] seen all the expert reports, but you have seen
[17] some.
[18] **A:** I'm pretty sure I have not.
[19] Those two OBs I did not.
[20] **Q:** Have you seen a report from Dr.
[21] Zacker out of the University of Cincinnati,
[22] Ronald Zacker?
[23] **A:** What is his specialty?
[24] **Q:** Pathology.
[25] **A:** I'm not sure.

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[1] **S. R. INGLIS**
[2] You want to send it over to me?
[3] **Q:** We might do that, but my question
[4] right now is whether you've seen it before.
[5] **A:** I don't...
[6] **Q:** So other than some of the expert
[7] reports and the twelve items, that's entirely
[8] what you reviewed?
[9] **A:** Uh-huh.
[10] **Q:** Is that a booklet of the medical
[11] records before you?
[12] **A:** Yes.
[13] **Q:** Your copy of your report seems to
[14] be different than my copy of your report, as I
[15] look at it.
[16] Could I see your copy for a
[17] minute? because it looks like the paper is
[18] different.
[19] **A:** Actually, look at the date.
[20] **Q:** You did one May 15, '04, and then
[21] the one I have is June 7, '04.
[22] Are there differences between
[23] these two documents?
[24] **MR. AUCIELLO:** Because I'll have
[25] that on the record, let's mark that as

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S. R. INGLIS

[1] number three, please.
 [2] (Whereupon, 5/15/05 Report was
 [3] marked Exhibit 3 for identification.)
 [4] **Q:** Doctor, I don't remember if I
 [5] asked it or not, but are there differences
 [6] between these two reports?
 [7] **A:** I don't know.
 [8] **Q:** On a cursory review, I'm not
 [9] finding any.
 [10] Is there a reason why you have —
 [11] the report was issued on two different
 [12] occasions, that you can recall?
 [13] **A:** I don't know.
 [14] **Q:** Other than the two dates on these
 [15] two reports, did you issue any other reports
 [16] or correspondence concerning this case?
 [17] **A:** No.
 [18] **Q:** Have you spoken to anyone other
 [19] than Mr. Becker concerning this case or Mr.
 [20] Loucas concerning this case?
 [21] **A:** No.
 [22] **Q:** Doctor, would you agree with me
 [23] that a physician can't guarantee patient
 [24] outcomes?
 [25]

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[1] **A:** Yes, I would agree with that.
 [2] **Q:** And that patients can have bad
 [3] outcomes from medical care even though they've
 [4] received good medical care?
 [5] **A:** Yes.
 [6] **Q:** And I suspect even your patients
 [7] have had bad outcomes.
 [8] **A:** Yes, they have.
 [9] **Q:** And you'd agree that the
 [10] physicians in caring for patients have to rely
 [11] on the facts and circumstances as they
 [12] encounter them in the clinical setting.
 [13] **A:** Yes.
 [14] **Q:** You would agree that they don't
 [15] have the benefit of hindsight, looking at the
 [16] end backwards, when they're treating a
 [17] patient.
 [18] **A:** That's correct.
 [19] **Q:** You would agree with me it's
 [20] easier to evaluate a case when you're looking
 [21] backwards in time as opposed to when the
 [22] events are occurring?
 [23] **A:** Yes.
 [24] **Q:** You knew what happened to this
 [25]

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S. R. INGLIS

[1] patient when you reviewed the case.
 [2] **Correct?**
 [3] **A:** It's hard to review a case
 [4] without knowing what happened.
 [5] **Q:** You were sent the medical
 [6] records, so you knew the outcome before you
 [7] started.
 [8] **A:** Yes.
 [9] **Q:** Doctor, how do you define the
 [10] standard of care?
 [11] **A:** It's what a reasonably prudent
 [12] physician would do in similar circumstances.
 [13] **Q:** Is it necessarily perfect care?
 [14] **A:** I would call it safe care.
 [15] **Q:** Safe care.
 [16] Can doctors have differences in
 [17] their approaches to illnesses and both be
 [18] within the standard of care and — be above or
 [19] within the standard of care?
 [20] **A:** Yes.
 [21] **Q:** Doctor, we touched on this a
 [22] little bit, but I want to make sure.
 [23] At the time of trial, you're not
 [24] going to come into court and identify any
 [25]

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S. R. INGLIS

[1] particular textbook as being authoritative and
 [2] reliable.
 [3] Is that correct?
 [4] You don't believe any of them are
 [5] authoritative and reliable?
 [6] **A:** Correct.
 [7] **Q:** Are there any particular journal
 [8] articles or pieces of the medical literature
 [9] that you intend to offer them to the effect
 [10] that they are reliable, set the standard of
 [11] care, or that they are authoritative regarding
 [12] any issue in this case?
 [13] **A:** No.
 [14] **Q:** If you do after this deposition
 [15] locate some article that you believe is
 [16] authoritative concerning any issue in the
 [17] case, I would ask that you notify Mr. Becker
 [18] so he can notify us.
 [19] **A:** Yes.
 [20] **Q:** Doctor, I represent Dr. Lucille
 [21] Stine. She's mentioned in your report. Let
 [22] me give you yours back. .
 [23] Does page seven contain all of
 [24] your criticisms of Dr. Lucille Stine?
 [25]

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[1] **S. R. INGLIS**
[2] **A:** Yes.
[3] **Q:** Doctor, what was the role of the
[4] house physician at Meridia Euclid Hospital
[5] back in the year 2000?
[6] **A:** My understanding of the role of
[7] that person was to be in the hospital and be a
[8] practicing obstetrician-gynecologist and take
[9] care of patients, evaluate patients until
[10] their own private Ob-Gyn could come in and
[11] take over.
[12] **Q:** Do you use house physicians here
[13] in New York?
[14] **A:** I'm sure some hospitals do.
[15] **Q:** Your hospitals, the two hospitals
[16] you mentioned you had privileges at?
[17] **A:** At our hospital, they are
[18] definitely not house physicians.
[19] At Cornell, maybe the residents
[20] in some way function as house physicians.
[21] **Q:** But you don't have the position
[22] of a house physician who's not a student who
[23] is in attendance at the hospital to deal with
[24] emergencies and/or cover for the attendings
[25] until they arrive?

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[1] **S. R. INGLIS**
[2] **A:** No, I'm actually going to change
[3] that.
[4] Actually, in our hospital, if
[5] there's a private patient coming in, our
[6] Ob-Gyns probably do function something like a
[7] house physician, yes.
[8] **Q:** So they stay at the hospital and
[9] handle any patient?
[10] **A:** 24 hours a day.
[11] **Q:** Have you ever worked in the role
[12] of a house physician?
[13] **A:** Yes.
[14] **Q:** When and where was that?
[15] **A:** When I worked in St. Barnabas
[16] Hospital.
[17] **Q:** And when was that?
[18] **A:** Any time in the last eight years.
[19] **Q:** So you go and you do a shift in
[20] the hospital and take all comers, whoever
[21] needs it?
[22] **A:** I do it once in a while, yes.
[23] **Q:** Dr. Stine's care began, I
[24] believe, around 23:30 or 23:35, where she did
[25] a history and physical.

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[1] **S. R. INGLIS**
[2] **A:** Yes.
[3] **Q:** Do you have criticism with the
[4] history and physical that she did?
[5] **A:** No, I do not.
[6] **Q:** I believe at 23:35 she issued a
[7] series of orders — and feel free to look at
[8] the medical records, if you'd like. I believe
[9] there's fifteen orders listed at 23:35.
[10] **A:** Yes, I see them.
[11] What was your question?
[12] **Q:** First I wanted you to see them.
[13] Do you have any criticisms of
[14] those orders?
[15] **A:** No.
[16] **Q:** In your report, you indicate that
[17] — I believe it's numbered one — that Dr.
[18] Stine should have told Dr. Bailin that he was
[19] needed in the hospital immediately.
[20] Is that accurately what the
[21] report says?
[22] **A:** Yes.
[23] **Q:** What did Dr. Stine tell Dr.
[24] Bailin?
[25] **A:** I do not know at this moment the

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[1] **S. R. INGLIS**
[2] details of the conversation, but I think it
[3] was not clearly stated to Dr. Bailin that the
[4] patient was severely ill and that he needed to
[5] come into the hospital immediately.
[6] **Q:** What's the basis for your belief
[7] that it was not clearly stated?
[8] **A:** Because her reply was that Dr.
[9] Bailin was coming in in the near future.
[10] **Q:** And from that you deduced that he
[11] was not informed of the patient's condition?
[12] **A:** Well, the fact that he did not
[13] arrive for about an hour would suggest that
[14] the communication was not clear.
[15] **Q:** I just want to make sure I
[16] understand this.
[17] Because the attending physician
[18] didn't arrive for an hour, it is your opinion
[19] that the house physician violated the standard
[20] of care in her communication to him.
[21] Does that accurately reflect your
[22] opinion?
[23] **A:** Yes.
[24] **Q:** So, it is a violation of the
[25] standard of care for a house physician if the

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[1] **S. R. INGLIS**
[2] attending physician for whatever reason
[3] doesn't arrive in a timely fashion?
[4] **A:** No.
[5] I would suggest it's the standard
[6] of care if you have a severely ill patient
[7] that you know specifically when that physician
[8] is going to arrive.
[9] **Q:** Tell me what information that Dr.
[10] Stine failed to relay to Dr. Bailin during
[11] their phone conversation.
[12] **A:** That his patient was severely
[13] ill, that he needed to come in and evaluate
[14] the patient immediately.
[15] **Q:** If Dr. Stine gave a complete
[16] history of the presentation of this patient
[17] and relayed to Dr. Bailin all the pertinent
[18] findings without saying she is severely ill,
[19] would that satisfy the standard of care?
[20] **A:** Can you repeat the question?
[21] **Q:** If Dr. Stine gave a complete
[22] history of the patient, what the labs were,
[23] what her presentation was, would that satisfy
[24] the standard of care?
[25] **A:** No, I would suggest it wouldn't.

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[1] **S. R. INGLIS**
[2] I think she needs to fill in the
[3] nature of the illness and the severity to Dr.
[4] Bailin so that it states that he is coming in
[5] immediately.
[6] **Q:** Do you know why Dr. Bailin didn't
[7] come in immediately?
[8] **A:** I have no idea.
[9] **Q:** So you don't know what reason he
[10] had in his mind to wait an hour?
[11] **A:** Correct.
[12] **Q:** You don't even know if his
[13] decision to wait an hour arose from something
[14] that Dr. Stine said or didn't say?
[15] **A:** No.
[16] **Q:** And as you admitted earlier, you
[17] don't know the substance of the conversation
[18] that occurred?
[19] **A:** No, I believe in the testimony
[20] that Dr. Stine gave it was that she gave
[21] report to Dr. Bailin and it was — and from
[22] what I read, it was not clear that the patient
[23] was severely ill and in need of his immediate
[24] presence.
[25] **Q:** Is there any clinical fact that

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[1] **S. R. INGLIS**
[2] you believe was withheld by Dr. Stine in her
[3] conversation with Dr. Bailin?
[4] **A:** Yes.
[5] **Q:** What?
[6] **A:** It's that he's needed in the
[7] hospital immediately.
[8] **Q:** That's a clinical fact about the
[9] patient's presentation, the condition of the
[10] patient?
[11] **A:** Correct.
[12] **Q:** What fact was omitted, just the
[13] statement that he needs to come in right now?
[14] **A:** The piece that was missing was
[15] the statement to Dr. Bailin that you need to
[16] come to the hospital immediately.
[17] **Q:** Now, tell me, how did this
[18] communication, this breach of the standard of
[19] care, cause the death of this patient?
[20] **A:** I believe that Dr. Bailin did not
[21] understand the severity of the case and
[22] delayed for an hour, came in whenever he came
[23] in, and then that was part of the delay in the
[24] entire care of this patient.
[25] **Q:** But I want to know how that

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[1] **S. R. INGLIS**
[2] delay, that — whatever it was from — he
[3] arrived before 1:15 because he delivered the
[4] baby at 1:15.
[5] **Q:** Correct?
[6] **A:** Correct.
[7] **Q:** Tell me how that hour of delay
[8] caused the death of this patient.
[9] **A:** Because I believe that if he had
[10] come in ten minutes after that phone call,
[11] that they very well may have done the
[12] C-section right then.
[13] **Q:** You believe had the C-section be
[14] done an hour earlier, this patient's life
[15] would have been saved?
[16] **A:** I think there's a reasonable
[17] chance, yes.
[18] **Q:** More likely than not?
[19] **A:** Yes.
[20] **Q:** Why?
[21] **A:** Because by delaying the case, the
[22] patient will get sicker. There's only one way
[23] to slow down what's happened to this patient,
[24] and that's to deliver as soon as possible.
[25] **Q:** What additional treatments or

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[1] **S. R. INGLIS**
[2] therapy would have been provided to the
[3] patient had Dr. Bailin arrived in less time
[4] than he took?
[5] **A:** I believe if Dr. Bailin had come
[6] in immediately, as he might have, there would
[7] have been a thought that maybe the patient
[8] should have gone to intensive care unit, maybe
[9] call maternal-fetal medicine, necrology, low
[10] dose dopamine, possible Swan-Ganz catheter,
[11] and blood pressure control.
[12] **Q:** Are you contending low dose
[13] dopamine would have been appropriate at this
[14] time?
[15] **A:** Possibly, yes.
[16] **Q:** I have to go back and tell my
[17] client what you said were the violations of
[18] the standard of care and why you think these
[19] violations caused the death of this patient.
[20] Is it your opinion that the
[21] standard of care mandated the administration
[22] of low dose dopamine to this patient during
[23] this hospitalization between 11:35 p.m. and
[24] 1:15 a.m.?
[25] **A:** I believe the standard of care

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[1] **S. R. INGLIS**
[2] mandated that someone, either Dr. Stine or Dr.
[3] Bailin, immediately start to move on whether
[4] this patient would be better off with all of
[5] those things.
[6] **Q:** Doctor, my question is: Should
[7] low dose dopamine have been administered to
[8] this patient between 11:35 p.m. and 1:15 a.m.
[9] during this admission?
[10] **A:** I don't know.
[11] **Q:** Should a Swan-Ganz catheter be
[12] placed during that time period?
[13] **A:** Possibly, yes.
[14] **Q:** Why?
[15] **A:** Because she had severe high blood
[16] pressure and her urine output was very low.
[17] (Beeper sounds)
[18] **THE WITNESS:** Can we stop for a
[19] minute?
[20] **MR. AUCIELLO:** Sure. You need to
[21] respond to a page.
[22] (Pause in proceedings)
[23] **Q:** Doctor, what effect would low
[24] dose dopamine have had on this patient?
[25] **A:** It possibly could have improved

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[1] **S. R. INGLIS**
[2] her urine output.
[3] **Q:** Is low dose dopamine generally
[4] indicated when a patient is hypotensive or
[5] hypertensive?
[6] **A:** Generally hypotensive.
[7] **Q:** Was Ms. McElfish hypotensive?
[8] **A:** No.
[9] **Q:** She was hypertensive?
[10] **A:** Right.
[11] **Q:** Would there have been a risk of
[12] giving low dose dopamine?
[13] **A:** Yes.
[14] **Q:** It's true it might have killed
[15] her?
[16] **MR. BECKER:** At what point are
[17] you talking about, when she was
[18] hypertensive?
[19] **Q:** When she was hypertensive, to
[20] give low dose dopamine.
[21] **A:** I would — any medication could
[22] kill a patient, you name it.
[23] There should have been a thought
[24] process as to what's going on. She needed
[25] help, and no one was called.

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[1] **S. R. INGLIS**
[2] **Q:** Doctor, I want to know, you don't
[3] know what the thought process was, do you?
[4] You only know what was written
[5] down.
[6] **A:** I know that there was no note
[7] written in the chart that said we gave serious
[8] consideration to Swan-Ganz, anti-hypertensive
[9] medication, or whatever, management of the
[10] case. And if a specialist had been called,
[11] then those things would have been addressed.
[12] I am not saying that
[13] automatically all of those things had to
[14] happen.
[15] **Q:** What specialist would have
[16] addressed those two items, the low dose
[17] dopamine and the Swan-Ganz catheter?
[18] **A:** Ideally, it would be the
[19] maternal-fetal medicine person, an
[20] anesthesiologist, or an intensive care or
[21] cardiologist. And ideally —
[22] (Beeper sounds)
[23] **THE WITNESS:** Can I answer that
[24] one too?
[25] **MR. AUCIELLO:** Yes.

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S. R. INGLIS

[1] (Pause in proceedings)
[2] **Q:** Doctor, if I understand your
[3] testimony, you believe the standard of care
[4] required that Dr. Stine or Dr. Bailin consult
[5] a maternal-fetal medicine specialist.
[6] **A:** No.
[7] I would say the standard of care
[8] is that there is a note addressing whether a
[9] — whether you're going to get a consult from
[10] the intensive care unit, maternal-fetal
[11] medicine, cardiology, nephrology, and whether
[12] you want to do a Swan-Ganz or address the
[13] blood pressure.
[14] **Q:** You're saying the Swan-Ganz
[15] should have been done.
[16] **A:** No.
[17] **Q:** You're not?
[18] **A:** I said a discussion.
[19] **Q:** All right.
[20] You're saying the low dose
[21] dopamine should have been a discussion also,
[22] you're not necessarily saying it should have
[23] been administered?
[24] **A:** The low dose dopamine at some

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S. R. INGLIS

[1] point in the care of the patient might have
[2] been useful. I'm not saying specifically at
[3] any time.
[4] **Q:** Is there a time when the standard
[5] of care mandated the administration of low
[6] dose dopamine to this patient?
[7] **A:** Not that I know of, that it is
[8] mandated, no.
[9] **Q:** Is there a point in time when the
[10] standard of care mandated that a Swan-Ganz
[11] catheter be placed?
[12] **A:** Possibly, yes.
[13] **Q:** When?
[14] **A:** Possibly on admission, possibly
[15] during the Cesarean section, possibly in the
[16] recovery room, and possibly at the time she
[17] actually decompensated.
[18] **Q:** Doctor, the possibly — either
[19] the standard of care required it or didn't or
[20] there's some variable factor that would call
[21] for it.
[22] So, can you tell me at what point
[23] did the standard of care require this patient
[24] to have a Swan-Ganz catheter?
[25]

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S. R. INGLIS

[1] **A:** When she decompensated, required.
[2] **Q:** When was that?
[3] **A:** That was at — I think it was
[4] 2:30.
[5] **Q:** And at no other point was it
[6] required?
[7] **A:** I would say it would be standard
[8] of care that there be a consideration of it, a
[9] discussion of it, with someone who is capable
[10] of doing that procedure.
[11] **Q:** Okay.
[12] **A:** Much earlier than 2:30.
[13] **Q:** But it should have been placed by
[14] 2:30 or at 2:30?
[15] **A:** Yes.
[16] **Q:** And had that been done, would
[17] that have changed the outcome?
[18] **A:** I would leave that to someone who
[19] is an intensivist to figure that out. I don't
[20] know.
[21] **Q:** You don't know.
[22] Are you just going to testify
[23] about the standard of care as opposed to
[24] causation?
[25]

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S. R. INGLIS

[1] **MR. BECKER:** No.
[2] **MR. AUCIELLO:** Okay, then, I'll
[3] continue asking. Otherwise, I would
[4] have...
[5] **Q:** Well, let me ask you this: Why
[6] don't you know whether placing a Swan-Ganz
[7] catheter at 2:30 in the morning would have
[8] changed the outcome?
[9] **A:** Because, frankly, the only way to
[10] know is if you're standing there in front of
[11] the patient and you know every detail, and
[12] then you would have a higher chance of knowing
[13] whether they could have made a difference at
[14] that point in time. It's hard for me now to
[15] know that.
[16] Possibly an intensivist that uses
[17] Swan-Ganz every day knows all the numbers, so
[18] they would have more knowledge of all the
[19] numbers of whether it could still have changed
[20] the outcome.
[21] **Q:** Now I've got to go back to the
[22] low dose dopamine.
[23] **Same question:** Was there a point
[24] in time — I think you already answered this,
[25]

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[1] **S. R. INGLIS**
[2] but just to make sure, there's not a point in
[3] time when the standard of care required the
[4] administration of low dose dopamine?
[5] **A:** Correct.
[6] **Q:** A nephrologist was consulted in
[7] this case.
[8] **Correct?**
[9] **A:** Correct.
[10] **Q:** That was Dr. Lautman?
[11] **A:** Yes.
[12] **Q:** Are you critical of Dr. Lautman's
[13] care?
[14] **A:** I think when Dr. Lautman saw the
[15] patient, there wasn't that much to be done.
[16] **Q:** Why is that?
[17] **A:** Because I think it was way after
[18] even 2:30.
[19] **Q:** By wasn't much to be done, does
[20] that mean everything had been done already?
[21] **A:** No, no, no.
[22] There was not much therapy that
[23] Dr. Lautman could come up with. And, frankly,
[24] I'm not even sure Dr. Lautman was the proper
[25] consult.

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[1] **S. R. INGLIS**
[2] It would have been better off if
[3] they consulted an intensivist instead of the
[4] nephrologist.
[5] **Q:** You said in your report that a
[6] nephrologist should have been considered at
[7] least.
[8] **Correct?**
[9] **A:** You could certainly consider it,
[10] and possibly a nephrologist could be of great
[11] benefit to this patient.
[12] But in general, the best people
[13] would be the cardiologist or the intensivist.
[14] **Q:** Doctor, your second criticism of
[15] Dr. Stine is numbered three.
[16] Was there a two at some point?
[17] **A:** I never noticed that. I don't
[18] know.
[19] **Q:** Did the standard of care mandate
[20] that any other form of blood pressure control
[21] as noted in your report be implemented with
[22] this patient?
[23] **A:** Yes.
[24] I would say the standard of care
[25] is that when her systolic blood pressure got

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[1] **S. R. INGLIS**
[2] over 160, that she would be treated with
[3] Hydralazine or some other anti-hypertensive
[4] from the moment she walked in the door.
[5] **Q:** Okay.
[6] Hydralazine?
[7] **A:** Hydralazine or a beta blocker.
[8] It doesn't make a difference much what
[9] medication, but systolic over 160, diastolic
[10] over 110 needs treatment.
[11] **Q:** When did that happen?
[12] **A:** Basically, she entered with those
[13] numbers, and it was not treated.
[14] **Q:** You indicate in your third
[15] criticism — it's numbered four — that Dr.
[16] Stine should have consulted with anesthesia
[17] for the planned Cesarean.
[18] **A:** Yes.
[19] **Q:** What difference would that have
[20] made?
[21] **MR. BECKER:** Objection.
[22] Asked and answered.
[23] Go ahead, you can answer again,
[24] doctor.
[25] **A:** By getting anesthesia involved at

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[1] **S. R. INGLIS**
[2] an earlier time, possibly they would have
[3] suggested other therapy for this patient.
[4] **Q:** Like what?
[5] **A:** Anti-hypertensives, consultation
[6] with other physicians.
[7] **Q:** Specifically —
[8] **A:** Swan-Ganz.
[9] **Q:** Specifically, what would have
[10] happened to the patient that would have
[11] changed the result had Dr. Stine contacted
[12] anesthesia by 11:50?
[13] **A:** Specifically, you would have
[14] another physician who knows a lot about all of
[15] those things I just said, and they may have
[16] suggested that all of those things happen.
[17] **Q:** More likely than not, would
[18] anything have changed more likely than not?
[19] **A:** I don't know. It's difficult to
[20] say.
[21] **Q:** I guess the same question with
[22] the fourth criticism — numbered five — what
[23] would the difference have been had this
[24] patient been considered for admission into the
[25] ICU?

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[1] **S. R. INGLIS**

[2] **A:** I think it's entirely likely that

[3] if the patient had been considered and in the

[4] intensive care and specialist contacted, that

[5] the therapy for the patient would have been

[6] substantially different.

[7] **Q:** How would it have been different?

[8] **A:** They may have recommended that

[9] the patient get a Swan-Ganz and that they read

[10] the blood pressure very carefully, and then

[11] the fluid management would be very carefully

[12] watched, the laboratory assessment would have

[13] been much more detailed.

[14] **Q:** Who would have been attending to

[15] this patient had she been in the ICU?

[16] **A:** The intensive care physician.

[17] **Q:** Do you know who that is?

[18] **A:** I do not know.

[19] **Q:** I take it you're not critical of

[20] Dr. Lautman.

[21] Is that true?

[22] **A:** I don't have detail of his

[23] reputation. As I remember, his — his

[24] consultation was done relatively late, and I'm

[25] not sure that his therapy could have changed

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[1] **S. R. INGLIS**

[2] the outcome.

[3] **Q:** Do you have any criticisms of Dr.

[4] Stine after Dr. Bailin arrived no later than

[5] 1:15 a.m.?

[6] **A:** I'm going to assume that the

[7] business relationship in that hospital is that

[8] Dr. Bailin takes over and is in charge of that

[9] patient and that all further decisions should

[10] be made by Dr. Bailin.

[11] Assuming that is how the practice

[12] of that hospital functions, then theoretically

[13] one can argue that all decisions going forward

[14] would be coming from, really, Dr. Bailin, and

[15] it's up to him to determine whether Dr. Stine

[16] would even help, whether he wants to even talk

[17] to Dr. Stine.

[18] **Q:** So based on that assumption —

[19] and I understand that's the assumption — you

[20] don't have any criticisms of Dr. Stine after

[21] Dr. Bailin's arrival, whenever it was?

[22] **A:** Correct.

[23] **MR. AUCIELLO:** Doctor, I don't

[24] think I have much more, but I'll let the

[25] other attorneys ask some questions, and

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[1] **S. R. INGLIS**

[2] I'll follow up.

[3] Somebody ready to go?

[4] (Pause in proceedings)

[5] **EXAMINATION**

[6] **BY MR. TREU:**

[7] **Q:** Doctor, my name is Kris Treu. I

[8] represent Dr. Bailin.

[9] Can you hear me all right?

[10] **A:** Yes, I can.

[11] **Q:** Okay.

[12] You have your report there, don't

[13] you?

[14] **A:** Yes.

[15] **Q:** Is the fact that this patient is

[16] a chronic hypertensive significant to your

[17] opinions in this case as it relates to the

[18] standard of care and Dr. Bailin?

[19] **A:** Yes.

[20] **Q:** And you note in your report at

[21] page five that the patient's blood pressure of

[22] 130 over 80 on March 2, 2000 indicates that

[23] the patient was a chronic hypertensive.

[24] Do I read that correctly?

[25] **A:** Yes.

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[1] **S. R. INGLIS**

[2] **Q:** Can you tell me on what you base

[3] your opinion that 130 over 80 indicates that

[4] this patient is a chronic hypertensive?

[5] **A:** Clearly, in the majority of the

[6] literature they're going to use the blood

[7] pressure of 140 over 90 as the criteria for

[8] chronic hypertension. I think in clinical

[9] medicine it's not that easy to absolutely say

[10] that you must hit those criteria to be called

[11] a chronic hypertensive and to have — it's

[12] better for the patient to be called chronic

[13] hypertensive, be given that diagnosis, and

[14] then given all of the care that we would give

[15] that patient who's a chronic hypertensive.

[16] **Q:** The accepted literature does, in

[17] fact, define hypertension as a suggested blood

[18] pressure increase to levels of systolic of 140

[19] or diastolic of 90.

[20] Does it not?

[21] **A:** Yes.

[22] **Q:** And are you disagreeing with that

[23] literature?

[24] **A:** I am disagreeing with the idea

[25] that to see a patient in your office who is 27

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[1] **S. R. INGLIS**
[2] years old and to have a blood pressure of 130
[3] over 80 and to call that normal.
[4] **Q:** Does that mean you necessarily
[5] call it chronic hypertension?
[6] **A:** I think in a lot of clinical
[7] medicine the standard is to just give that
[8] sort of patient the diagnosis of hypertension
[9] and all of the care.
[10] **Q:** Is it your testimony in this case
[11] that the standard of care requires a physician
[12] to treat a patient with a blood pressure of
[13] 130 over 80 as a chronic hypertensive?
[14] **A:** I would say the standard of care
[15] is to — is to carefully monitor that patient,
[16] and I would say that a lot of people will give
[17] that patient the diagnosis of chronic
[18] hypertension to make sure that that monitoring
[19] occurs.
[20] **Q:** That being said, you would agree
[21] with me that the standard — the understanding
[22] in your specialty is that chronic hypertensive
[23] is not — doesn't reach that level until they
[24] are 140 over 90.
[25] True?

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[1] **S. R. INGLIS**
[2] **A:** We agree the strict criteria is
[3] 140 over 90. There's no doubt about that.
[4] **Q:** All right.
[5] And that is generally understood
[6] to be a patient who reaches that blood
[7] pressure within the first twenty weeks of
[8] pregnancy.
[9] Correct?
[10] **A:** Correct.
[11] **Q:** Did Ms. McElfish meet that
[12] criteria in this pregnancy?
[13] **A:** She did not meet that blood
[14] pressure criteria that we know of, no.
[15] **Q:** Okay.
[16] The third criticism that you list
[17] in your report on page five is that the
[18] practitioners in this case have the incorrect
[19] due date for this patient.
[20] **A:** Yes.
[21] **Q:** That's based on the prenatal flow
[22] records.
[23] Is that correct?
[24] **A:** Yes.
[25] **Q:** Would you agree with me that

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[1] **S. R. INGLIS**
[2] during Ms. McElfish's admission to Meridia
[3] Euclid Hospital, her outpatient evaluation
[4] summary indicates her EDD by sonogram is
[5] September 18?
[6] **A:** I believe it is the case, yes.
[7] **Q:** And that's also documented in the
[8] records during her admission on September 16.
[9] Correct?
[10] **A:** I don't have that in front of me,
[11] but I'll leave it to you this way: I believe
[12] there was a lot of confusion as to what her
[13] gestational age was, and out of — that
[14] confusion is very significant when you're
[15] pregnant and you have a very complicated
[16] pregnancy. The failure to clearly write on
[17] the piece of paper what the proper due date is
[18] and use it is concerning.
[19] **Q:** Other than that, are you aware of
[20] any testimony indicating that there was mass
[21] confusion about this patient's delivery date,
[22] estimated delivery date?
[23] **A:** In terms of testimony, I don't
[24] know of any vast confusion, but I clearly saw
[25] through the record multiple places where

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[1] **S. R. INGLIS**
[2] different people were saying different
[3] gestational ages. I think it's even on the
[4] admission — the very last admission, it even
[5] says question mark there versus that.
[6] **Q:** With respect to the management of
[7] chronic hypertension set forth in your fourth
[8] criticism on page five, what baseline work-ups
[9] does the literature recommend?
[10] **A:** It usually recommends if you're a
[11] chronic hypertensive 24-hour urine, complete
[12] blood count, liver functions, maybe an
[13] antinuclear antibody if you have hypertension,
[14] maybe uric acid, and maybe other tests
[15] depending on the specifics of that patient.
[16] **Q:** You're aware, of course, that the
[17] patient was admitted to the hospital on August
[18] 21 for work-up.
[19] Correct?
[20] **A:** Correct.
[21] **Q:** And during that inpatient
[22] admission, her urine protein was negative.
[23] Correct?
[24] **A:** As I remember, yes, that is.
[25] **Q:** Her creatinine was within normal

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S. R. INGLIS

[1] limits.
[2] True?
[3] A: I'm not sure of that. Hang on a
[4] minute.
[5] You said 8/21?
[6] Q: Correct.
[7] A: What was the creatinine level, do
[8] you know?
[9] I see it, it was zero point seven
[10] and the BUN was eleven, and neither of these
[11] are normal.
[12] Creatinine is zero point seven
[13] and BUN is 11.
[14] Q: Is that within normal limits?
[15] A: I would say for pregnancy, no.
[16] Q: What makes it different for
[17] pregnancy?
[18] A: In pregnancy, the creatinine
[19] clearance goes up substantially, so you expect
[20] the creatinine to come down. So, you have a
[21] zero point seven, which is upper limit of
[22] normal for pregnancy, and then the BUN of
[23] eleven is high. So if you did a 24-hour
[24] urine, you may find there's already renal
[25]

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S. R. INGLIS

[1] insufficiency.
[2] Q: How was her uric acid level?
[3] A: I don't know.
[4] Q: Why not?
[5] A: I don't see it in front of me.
[6] Q: Were her PIH labs normal?
[7] A: Well, it depends on your
[8] definition of normal.
[9] A BUN of eleven and a creatinine
[10] of zero point seven are questionable to begin
[11] with.
[12] Q: What about liver enzymes?
[13] A: The liver enzymes were normal. I
[14] do remember that.
[15] Q: And what were her blood pressures
[16] during that confinement?
[17] A: I see two blood pressures; I see
[18] 123 over 56, and then 144 over 86 while she's
[19] resting in bed.
[20] Q: Are those normal?
[21] A: No.
[22] Q: What's abnormal?
[23] A: Clearly, anything over 140
[24] systolic is not normal, and the 86 is almost
[25]

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S. R. INGLIS

[1] 90 so that's almost abnormal too.
[2] By any definition, those are not
[3] normal.
[4] Q: So the systolic was four points
[5] over the normal level?
[6] A: Correct.
[7] And that's enough to make you
[8] mild preeclampsia.
[9] Q: But, again, there's no indication
[10] of any abnormality in the kidney function.
[11] True?
[12] A: No.
[13] There's an indication. The BUN
[14] was eleven and the creatinine zero point
[15] seven, which is the upper limit of normal for
[16] pregnancy.
[17] Q: But it's still normal?
[18] A: The BUN is not normal. The
[19] creatinine of zero point seven is the upper
[20] limit of normal for pregnancy.
[21] Q: Ms. McElfish was worked up again
[22] on December 5, 2000.
[23] Correct?
[24] A: Yes.
[25]

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S. R. INGLIS

[1] Q: How was her creatinine at that
[2] time?
[3] A: As I remember, it was better. I
[4] think it might have been zero point five.
[5] Q: Her uric acid?
[6] A: As I remember, it was four point
[7] something.
[8] Q: Normal?
[9] A: Yes.
[10] Q: AST was fifteen.
[11] Correct?
[12] A: Correct.
[13] Q: Anything abnormal about that?
[14] A: No.
[15] Q: Her ALT was 24.
[16] Correct?
[17] A: As I remember, yes.
[18] Q: That's normal as well?
[19] A: Yes.
[20] Q: Her blood pressure on that date
[21] at two in the afternoon, 1400 hours, was 124
[22] over 69?
[23] A: I don't have it in front of me.
[24] As I remember, the blood pressure
[25]

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S. R. INGLIS

[1] was better when she got in the hospital and
[2] was resting.
[3] **Q:** And the repeat blood pressure
[4] done shortly after that was 130 over 70.
[5] **A:** Correct?
[6] **A:** Yes.
[7] **Q:** And during that confinement, her
[8] blood pressures continued to remain well
[9] within the normal range.
[10] **A:** True?
[11] **A:** Yes, they were at that moment
[12] normal, yes.
[13] **Q:** With no evidence of any kidney
[14] malfunction?
[15] **A:** Well, there was certainly some
[16] evidence when she had a one plus protein when
[17] she was in her outpatient visit the same day.
[18] **Q:** Talking about in the hospital.
[19] **A:** Oh, in the hospital.
[20] If the urines were negative, then
[21] at least those dip sticks were normal.
[22] **Q:** Any evidence of any other end
[23] organ involvement during that admission?
[24] **A:** Well, if she was complaining of
[25]

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S. R. INGLIS

[1] headache, that would be concerning.
[2] **Q:** Was she?
[3] **A:** I don't know whether she'd
[4] stopped complaining, but earlier that day she
[5] did have a headache, yes.
[6] **Q:** But there's no documentation of
[7] that in hospital?
[8] **A:** Not that I have right in front of
[9] me. I don't know.
[10] **Q:** So, can we say that during the
[11] time of that confinement, based on all of the
[12] studies and tests that were done during that
[13] confinement, there's no evidence that she was
[14] suffering from preeclampsia or any end organ
[15] involvement from preeclampsia?
[16] **A:** I'm not sure you can say that.
[17] **Q:** Why not?
[18] **A:** Because to really determine
[19] whether she had preeclampsia she needed more
[20] work.
[21] **Q:** I'm asking you based on the
[22] studies that were done that day.
[23] **A:** You cannot come to that
[24] conclusion.
[25]

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S. R. INGLIS

[1] **Q:** Is there anything based on the
[2] studies that were done that day that would
[3] lead you to the conclusion that she was
[4] preeclamptic?
[5] **A:** Yes, a blood pressure of 160 over
[6] 86, one plus protein, fatigue, headache,
[7] numbness in the hands, all of that does make
[8] me concerned that she does have preeclampsia.
[9] **Q:** Which is why she was taken in the
[10] hospital and these studies were done.
[11] **A:** True?
[12] **A:** Yes.
[13] **Q:** And none of those studies nor any
[14] of the examinations done in the hospital that
[15] day indicated any signs or symptoms of
[16] preeclampsia.
[17] **A:** Correct?
[18] **A:** They did not do the tests to make
[19] sure the patient did not have preeclampsia.
[20] None of the tests that they did
[21] do indicated any signs or symptoms of
[22] preeclampsia, correct.
[23] The tests they did earlier that
[24] day did show there were signs and symptoms of
[25]

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S. R. INGLIS

[1] preeclampsia, yes.
[2] **Q:** Doctor, could you answer the
[3] question I'm asking you, please?
[4] My question was quite simple;
[5] that is, the tests and the studies and
[6] observations that were done during the
[7] confinement on September 5, 2000 did not
[8] disclose any evidence, signs, or symptoms of
[9] preeclampsia.
[10] Isn't that true?
[11] **MR. BECKER:** Objection.
[12] Asked and answered.
[13] **MR. TREU:** No, it wasn't.
[14] **A:** No, they did not.
[15] **Q:** With respect to the criticisms
[16] contained in paragraph five of your report, it
[17] begins at the top of page 6, do you believe
[18] the anti-hypertensive therapy during Ms.
[19] McElfish's course was indicated?
[20] **A:** Yes.
[21] **Q:** What factors warranted the
[22] administration of anti-hypertensive medication
[23] during this patient's prenatal period?
[24] **A:** Any time her systolic blood
[25]

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[1] **S. R. INGLIS**
[2] pressure went over 150 or her diastolic went
[3] over 105, it would be standard to start
[4] anti-hypertensive therapy.
[5] **Q:** For how long?
[6] **A:** You would basically keep it going
[7] to — until you had a therapeutic effect to
[8] keep the blood pressure down around a 140 over
[9] 90 range. As long as you had that, then
[10] you've got the proper therapy.
[11] **Q:** Was there any evidence from the
[12] confinements in August and September that this
[13] patient needed hypertensive medication,
[14] anti-hypertensive medication?
[15] **A:** Yes.
[16] **Q:** And what was that?
[17] **A:** Her hypertension.
[18] **Q:** During the time she was confined?
[19] **A:** Yes, in one of those admissions
[20] she had a 140 over 88.
[21] **Q:** Why don't you tell me, doctor,
[22] based on your review of the records, when this
[23] patient first should have been placed on
[24] anti-hypertensive medication.
[25] **A:** I would suggest that it would

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[1] **S. R. INGLIS**
[2] start the first time her systolic blood
[3] pressure was over 150 and the diastolic was
[4] over 105, and that would be — 8/21 is the
[5] first time I see a blood pressure of that
[6] degree of hypertension.
[7] At that time, then, if that is
[8] prolonged, continuing to have that degree of
[9] hypertension, then she would be started on an
[10] anti-hypertensive medication.
[11] **Q:** We know it wasn't prolonged on
[12] that date, don't we, on August 21?
[13] **A:** We don't know because they did
[14] not check blood pressures other than, you
[15] know, about three times total.
[16] **Q:** Well, we know that when she was
[17] put in the hospital that day that neither of
[18] her blood pressures were abnormal.
[19] True?
[20] **A:** We do know for that interval of
[21] time, that, yes, that they were not elevated
[22] or not elevated to the level I just said to
[23] require —
[24] **Q:** So, would you have started her on
[25] anti-hypertensive medication in the office

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[1] **S. R. INGLIS**
[2] before you admitted her for these tests?
[3] **A:** No, I would not have started
[4] anti-hypertensives the first time I started
[5] that blood pressure.
[6] **Q:** So, would you have started them,
[7] then, based on what you found during that
[8] confinement on August 21?
[9] Would that justify starting that
[10] patient on anti-hypertensives?
[11] **A:** What I would have done is had the
[12] patient admitted and watched the blood
[13] pressure carefully, and then if she continued
[14] to have blood pressures of 150 or higher or
[15] diastolic of 105, I would have started
[16] anti-hypertensive medication.
[17] But as your patient specifically
[18] said, for those blood pressures when she was
[19] observed in the hospital, then I guess the
[20] answer would be no since they didn't admit
[21] her.
[22] **Q:** So then going forward, when would
[23] you have prescribed anti-hypertensives for
[24] this patient?
[25] **A:** The next day when her blood

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[1] **S. R. INGLIS**
[2] pressure was 140 over 100, the next day.
[3] **Q:** And then how long would you have
[4] maintained her on those medications?
[5] **A:** All the way until delivery most
[6] likely, considering her blood pressure tends
[7] to be very high all the way.
[8] **Q:** Did it?
[9] **A:** The only one that I see is still
[10] hypertensive but is a little better, the only
[11] one I see there is on 9/8 she is 134 over 84,
[12] then they checked again 154 over 84, so she
[13] went right back up again.
[14] **Q:** What about during the admission
[15] of September 5?
[16] **A:** I think we already went through
[17] that.
[18] **Q:** There were not.
[19] Correct?
[20] **A:** The blood pressure was better for
[21] that little interval of time.
[22] **Q:** And what about on September 14
[23] when she had her NST done in the hospital,
[24] what was her blood pressure on that date?
[25] **A:** I don't have it.

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[1] **S. R. INGLIS**
[2] Could you remind me?
[3] **Q:** 130 over 70.
[4] **A:** So that's abnormal.
[5] **Q:** Normal?
[6] **A:** No, it's not.
[7] **Q:** It's not?
[8] **A:** 130 over 70?
[9] **Q:** Yeah.
[10] **A:** It is not a normal blood pressure
[11] in pregnancy by any stretch.
[12] **Q:** Is it hypertensive?
[13] **A:** Yes.
[14] **Q:** Not according to any definition
[15] in the literature.
[16] **Correct?**
[17] **A:** 130 — did you say 70 or 80?
[18] **Q:** 70.
[19] **A:** 70 is not a normal blood pressure
[20] when you're pregnant and you're 28 years old.
[21] **Q:** You're familiar with the — are
[22] you a member of ACOG?
[23] **A:** Yes.
[24] **Q:** Are you familiar with their
[25] publications?

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[1] **S. R. INGLIS**
[2] **A:** Yes.
[3] **Q:** Are you familiar with the
[4] technical bulletin dealing with hypertension
[5] in pregnancy?
[6] **A:** Yes.
[7] **Q:** Is that a reliable publication?
[8] **A:** It's a good publication.
[9] **Q:** Is it something that most
[10] practitioners rely on to provide them with
[11] reliable and reasonable information in their
[12] practice?
[13] **A:** Some will rely on it, yes.
[14] **Q:** Don't most?
[15] **A:** Maybe most.
[16] **Q:** But not you?
[17] **A:** I am interested in taking care of
[18] the patient. A blood pressure of 130 over 80
[19] in a 28 year old is not normal.
[20] **Q:** So, just so the record is clear
[21] it was 130 over 70, but I don't think it —
[22] **A:** I'm sorry?
[23] **Q:** — matters to you.
[24] With respect to the criticism
[25] contained in paragraph six of your report,

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[1] **S. R. INGLIS**
[2] what literature supports home blood pressure
[3] monitoring is issued when blood pressure
[4] control is difficult?
[5] (Beeper sounds)
[6] **THE WITNESS:** Can you hang on a
[7] second?
[8] **MR. TREU:** Sure.
[9] **MS. DISALVIO:** Why don't you take
[10] a few minutes, if you don't mind?
[11] (Recess taken)
[12] (Record read)
[13] **MR. BECKER:** I think he wants to
[14] know if you can cite any literature to
[15] support number six off the top of your
[16] head.
[17] **Q:** Doctor, I can't tell if you're
[18] pondering a question or waiting for me to ask
[19] another question.
[20] **A:** I am pondering.
[21] **THE WITNESS:** Would you mind
[22] repeating the question?
[23] (Record read)
[24] **A:** In paragraph six, what I am — I
[25] don't have any specific literature for you on

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[1] **S. R. INGLIS**
[2] that. I'm simply stating that using home
[3] blood pressure monitoring may help you to
[4] determine better what her blood pressure
[5] status is, and it could be used instead of
[6] admitting the patient to the hospital or
[7] whatever. It was just an option that could
[8] have been considered.
[9] I don't think there was a
[10] standard.
[11] **Q:** Thank you. I jumped to a
[12] conclusion in that question.
[13] Is there anything in numbered
[14] paragraph six on page six where you are
[15] indicating that there was some breach of
[16] accepted standards of care on behalf of Dr.
[17] Bailin, or are these just general statements
[18] that you're making?
[19] **A:** Correct, I think these are
[20] general statements and I do not think they
[21] directly apply.
[22] **Q:** Okay. Thank you. We'll move on
[23] to paragraph seven, then.
[24] Is it your opinion in this case
[25] that this child should have been delivered

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S. R. INGLIS

[1] prior to September 17, 2000?
[2]
[3] **A:** Yes.
[4] **Q:** Do you have an opinion as to when
[5] this child should have been delivered?
[6] **A:** I do not have a specific, no.
[7] **Q:** Would you agree with the
[8] statement that delivery is always an
[9] appropriate option in the term patient with
[10] hypertension; however, in a patient with an
[11] unfavorable cervix who exhibits only mild
[12] blood pressure elevations, minimal
[13] proteinuria, and no evidence of either
[14] maternal end organ development or fetal
[15] compromise, delivery may be delayed in an
[16] effort to obtain a more favorable cervix prior
[17] to induction?
[18] **A:** Can you state it one more time
[19] for me?
[20] **Q:** Sure.
[21] Delivery is always an appropriate
[22] option in the term patient with hypertension;
[23] however, in a patient with an unfavorable
[24] cervix who exhibits only mild blood pressure
[25] elevations, minimal proteinuria, and no

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S. R. INGLIS

[1] evidence of either maternal end organ
[2] development or fetal compromise, delivery may
[3] be delayed in an effort to obtain a more
[4] favorable cervix prior to induction.
[5]
[6] **A:** Yes.
[7] **Q:** Is it your opinion that Ms.
[8] McElfish did not meet that definition?
[9] **A:** Yes.
[10] **Q:** In what way?
[11] **A:** There was not enough monitoring
[12] to determine whether she was — would fit that
[13] criteria.
[14] **Q:** Again, to meet the accepted
[15] standard of care, what additional monitoring
[16] has to be done in this case?
[17] **A:** She needed to be worked up for
[18] preeclampsia and she needed blood pressure
[19] monitoring.
[20] **Q:** And what would you look for in
[21] the blood pressure monitoring to indicate that
[22] earlier delivery was necessary?
[23] **A:** If the blood pressure was high
[24] despite bed rest and she had any evidence of
[25] preeclampsia, then she wouldn't fit the

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S. R. INGLIS

[1] criteria and she would need to be delivered.
[2]
[3] **Q:** Can we agree that every time that
[4] she was put on bed rest in the hospital or was
[5] laying on her back having an NST done and her
[6] blood pressures were taken, they were within
[7] normal range according to the ACOG criteria?
[8] **A:** No.
[9] **Q:** When was that not the case?
[10] **A:** The time when she got a 140 over
[11] 88 or 144 over 86. I think it was 8/21.
[12] But if it will make you feel
[13] better, I do agree she seems to have done a
[14] little better when lying on her back in the
[15] hospital.
[16] **Q:** Aside from that one slightly
[17] abnormal blood pressure according to the ACOG
[18] criteria, otherwise whenever she was laying
[19] down she had normal blood pressures.
[20] Isn't that true?
[21] **A:** I'm not sure I would call them
[22] normal.
[23] **Q:** According to the ACOG criteria,
[24] 140 over 90.
[25] **A:** Okay, if you want to use

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[1] specifically those numbers that you're pulling
[2] out from an ACOG bulletin in whatever way you
[3] want, I would say there was clearly one time
[4] when we know that she did not fit those
[5] criteria, but there may have been many more
[6] because she never was admitted and put on bed
[7] rest to check.
[8] **Q:** Was Ms. McElfish's cervix ever
[9] favorable prior to September 16, 2000?
[10] **A:** I'm not actually sure at this
[11] moment. I'm assuming you can tell me it was
[12] not.
[13] **Q:** Hold on one second, doctor. I'm
[14] looking for something.
[15] Again, based on the laboratory
[16] studies that were conducted, doctor, there was
[17] no evidence of either maternal end organ
[18] development or fetal compromise.
[19] True?
[20] **A:** I think we've already gone
[21] through this.
[22] **Q:** Is that a yes?
[23] **A:** I believe the reply I gave before
[24] was it was not checked. We don't know.
[25]

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[1]
[2] **Q:** I'm saying based on what was
[3] checked.
[4] **A:** Specifically, if you're talking
[5] about when the patient was admitted to the
[6] hospital, those tests are not administered on
[7] outpatient basis. I think I already said no,
[8] there was nothing that they did that clearly
[9] showed us that she had preeclampsia.
[10] **Q:** Now, I'm looking at paragraph
[11] nine, page six. You say from August 21 on,
[12] the patient needed weekly visits, nonstress
[13] tests, and frequent blood pressure checks
[14] preferably at home.
[15] Were her visits after August 21,
[16] in fact, weekly visits?
[17] **A:** I think they may have been
[18] weekly.
[19] **Q:** Did she have routine nonstress
[20] tests done from that point forward?
[21] **A:** I believe she did.
[22] **Q:** And those nonstress tests were
[23] always within normal limits?
[24] **A:** I believe they were, yes.
[25] **Q:** You indicate in criticism number

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[1] ten on page seven of your report that
[2] maternal-fetal medicine consultation was
[3] required.
[4] Is that your opinion to a degree
[5] of probability to meet the accepted standard
[6] of care?
[7] **A:** I would suggest that I am really
[8] stating number ten there as a general rule
[9] unless you feel — the physician feels
[10] completely comfortable with the management of
[11] the case.
[12] **Q:** Okay.
[13] Now you've got — again,
[14] following that paragraph ten on page seven,
[15] you've had a heading entitled intrapartum
[16] substandard care. I do not see Dr. Bailin's
[17] name referenced in that particular subheading.
[18] Can I be comfortable in the fact
[19] that you are not going to opine on the fact
[20] that Dr. Bailin failed to meet the standard of
[21] care for the intrapartum period for this
[22] patient?
[23] **A:** Well, no, I don't think you can
[24] come to that conclusion.
[25]

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[1]
[2] **Q:** Okay.
[3] Again, I don't see his name
[4] mentioned there.
[5] Do you have criticisms of him
[6] during this time period?
[7] **A:** Well, assuming that Dr. Bailin
[8] was the one who took over responsibility for
[9] the patient as soon as he arrived, then any of
[10] my remarks of anything that was — could have
[11] been different would apply to him.
[12] **Q:** Well, let me see if I
[13] understand.
[14] Dr. Bailin, as you know, was
[15] called a few minutes before midnight.
[16] Correct?
[17] **A:** I'm not sure of the time. I
[18] actually thought it was earlier.
[19] **MR. TREU:** Somebody say something
[20] at that end?
[21] **THE WITNESS:** I don't know what
[22] the question is.
[23] **Q:** The question is: Is it not your
[24] understanding that Dr. Bailin was called at a
[25] few minutes before midnight?

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[1]
[2] **A:** Yes, I believe that is correct.
[3] **Q:** And as you discussed earlier in
[4] your deposition, he arrived approximately an
[5] hour later?
[6] **A:** Yes.
[7] **Q:** Around one in the morning?
[8] **A:** I believe something like that,
[9] yes.
[10] **Q:** And recognizing the situation,
[11] you'd agree with me that the only treatment
[12] for a patient who is in the throes of HELLP
[13] syndrome is rapid delivery of the child.
[14] Is that true?
[15] **A:** Absolutely, yes.
[16] **Q:** And Dr. Bailin did that in this
[17] case.
[18] Can we agree on that?
[19] **A:** Yes.
[20] **Q:** The child was delivered by 1:18
[21] in the morning?
[22] **A:** Yes.
[23] **Q:** Are we now beyond the intrapartum
[24] portion of the case once the child is
[25] delivered?

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[1] **A:** Well, technically, yes, they
[2] would begin postpartum at that moment.
[3] As to whether there is — are you
[4] saying there's no issue with how Dr. Bailin
[5] performed prior to that moment?
[6] **Q:** All I'm trying to do is make sure
[7] I understand the parameters, number one.
[8] Then I was going to ask you the
[9] question: What was it between 1 o'clock when
[10] Dr. Bailin arrived and 1:18 when he delivered
[11] this child that he should have done
[12] differently if you believe he should have?
[13] **A:** I would say there's nothing that
[14] I would say that he should have done
[15] differently. My only question is that when
[16] you go to the care that occurred for when she
[17] got admitted to when he arrived, I don't know
[18] where the responsibility lies between Dr.
[19] Stine, Dr. Bailin, but Dr. Bailin may have not
[20] performed well. I don't know.
[21] **Q:** As we sit here today, you can't
[22] say during that time period between the time
[23] he was called and the time that he arrived,
[24] you don't know whether there was something

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[1] more he should have done during that time
[2] period or not?
[3] **A:** Correct.
[4] My instinct is to — the
[5] physician that is there seeing the patient is
[6] primarily responsible, and then they need to
[7] take over. And then — and I don't know if
[8] that's right, but that's how I look at it.
[9] **Q:** Okay.
[10] You're aware that Dr. Stine is
[11] actually a maternal-fetal medicine specialist?
[12] **A:** I am, yes.
[13] **Q:** And you're just not clear in your
[14] mind as to what information was relayed to Dr.
[15] Bailin when he was initially called.
[16] Is that true?
[17] **A:** Correct.
[18] **Q:** Or the extent to which he was —
[19] strike that question. So, let's go, then, to
[20] the postpartum care.
[21] Are you aware of whether there
[22] was, in fact, an intensivist available at this
[23] institution for consultation?
[24] **A:** I'm not aware.

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[1] **Q:** What is your understanding as to
[2] when Dr. Lautman was first contacted by Dr.
[3] Bailin on consult?
[4] **A:** My understanding is that it was
[5] probably even after 2:30.
[6] **Q:** I think if you look at records,
[7] that will indicate that he was called before
[8] 2:30, at approximately 2:15.
[9] **A:** Okay.
[10] **Q:** And he was consulted on
[11] management of the patient's — at that point,
[12] I believe hypotension after she had received
[13] the — what was it?
[14] **A:** I think Apresoline.
[15] **Q:** Right.
[16] **A:** That's Hydralazine.
[17] **Q:** First of all, was it in your mind
[18] appropriate to give her that Hydralazine at
[19] that time?
[20] **A:** Would you mind if we go back and
[21] look?
[22] I actually don't remember that
[23] well.
[24] **Q:** Please do.

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[1] **A:** Do you have any idea where the
[2] records would be of that?
[3] **MR. AUCIELLO:** My summary
[4] indicates it's in the nursing notes.
[5] I don't have my records with me.
[6] **A:** I think I see Apresoline at 2:04
[7] and another one at 2:15, five milligrams.
[8] **Q:** The question is: Was that
[9] appropriate therapy at that time?
[10] **A:** I'm just checking the blood
[11] pressures just before that.
[12] I don't know the answer to that
[13] one.
[14] **Q:** Okay.
[15] Was it appropriate for Dr. Bailin
[16] to consult with Dr. Lautman?
[17] **A:** Yes, it was appropriate for him
[18] to consult anybody he wanted to help.
[19] **Q:** And just so I understand, what
[20] are your criticisms of Dr. Bailin's care of
[21] this patient postoperatively?
[22] **A:** I think they're in the report. I
[23] believe that after she was delivered, she was
[24] very, very sick. And all of the things that I

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[1] think could have happened before the delivery
[2] could have happened right after the delivery.
[3] **Q:** We know he consulted with a
[4] nephrologist, and we know he consulted with a
[5] hematologist postoperatively.
[6] **A:** Okay.
[7] **Q:** And we know that blood products
[8] were given and fluids were given.
[9] **A:** Yes.
[10] **Q:** So I guess my question is: What
[11] more should Dr. Bailin have done in your
[12] opinion to meet the accepted standard of care
[13] postpartum?
[14] **A:** She needed to be monitored in a
[15] critical care sort of setting, either in the
[16] recovery room there or up in an ICU, and she
[17] needed consultation from those other
[18] specialists, such as an intensivist or
[19] cardiologist or maternal-fetal medicine, and
[20] she needed all of those things basically in
[21] the recovery room when she left the operating
[22] room.
[23] Possibly she should have gone
[24] straight from the operating room to the ICU.
[25]

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[1] **Q:** Do you have an opinion as to at
[2] what point in this patient's course it was too
[3] late to save her?
[4] **A:** It's not easy to say. I do think
[5] — I guess it would be sometime after the
[6] 2:30 episode, it would have been. But I would
[7] leave that to an intensive care specialist or
[8] something like that.
[9] **Q:** Okay.
[10] Doctor, when you reviewed the
[11] records in this case, did you make any
[12] markings or highlightings or anything of that
[13] nature on the documents?
[14] **A:** Not really much, no, I don't see
[15] any.
[16] **Q:** Did you make any notations in the
[17] margins of any of the depositions or anything
[18] that you read?
[19] **A:** No.
[20] **Q:** Are you one of those people who
[21] puts Post-its on things when they go through
[22] to mark things that they want to go back and
[23] look at?
[24] **A:** Yeah, I probably did, yes.
[25]

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[1] **Q:** Would you have made notations as
[2] well or just stuck a Post-it in the page?
[3] **A:** Probably a Post-it.
[4] **Q:** And why would you do that?
[5] **A:** Just significant events where I
[6] can tell what somebody was thinking, what they
[7] were doing with the care of the patient.
[8] During a deposition, if someone
[9] figures out at this moment the patient was
[10] very sick, that's — at that moment you can at
[11] least know what's going on in their head.
[12] **Q:** Did you bring all those documents
[13] with you to the deposition today?
[14] **A:** I did not.
[15] Those depositions, I can't even
[16] find right now. They may be somewhere, but
[17] they're not easily found.
[18] **Q:** What did you bring to the
[19] deposition today?
[20] **A:** Just the prenatal record and my
[21] report, I think is it.
[22] And I did bring back, though —
[23] there were a few reports that I reviewed just
[24] recently, and I brought those back, and George
[25]

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[1] Loucas took those with him.
[2] **Q:** And you said the prenatal
[3] records.
[4] Did you review the actual labor
[5] and delivery records?
[6] **A:** Yes.
[7] **Q:** Do you have those?
[8] **A:** Yes, I believe this is a complete
[9] — yes.
[10] **Q:** You've made reference to a
[11] booklet of reports.
[12] **A:** Yeah, it was a booklet of expert
[13] reports, I think was the proper term.
[14] **Q:** Is that something that you had
[15] reviewed prior to yesterday?
[16] **A:** No.
[17] **Q:** So that was something — a book
[18] that was shown to you yesterday when you met
[19] with counsel?
[20] **A:** Yes.
[21] **Q:** Did that include both plaintiff
[22] and defense expert reports?
[23] **A:** Yes, both.
[24] **Q:** Aside from those documents, have
[25]

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[1] *S. R. INGLIS*

[2] you reviewed anything additional to the items

[3] set forth in your report letter that was

[4] provided to us dated June 7, 2004?

[5] **A:** There's one more thing, I think.

[6] I reviewed the deposition of Dr.

[7] Stockwell. That and those reports that were

[8] in that folder.

[9] And that was it, in addition to

[10] this stuff you see on my report. That was

[11] it.

[12] **Q:** So you have read Dr. Stockwell's

[13] report — I mean deposition.

[14] **A:** Deposition, correct.

[15] **MR. TREU:** Doctor I'm going to

[16] take a break for now, see if anyone else

[17] has any questions for you.

[18] **EXAMINATION**

[19] **BY MS. DISALVIO:**

[20] **Q:** Dr. Inglis — am I pronouncing

[21] that all right?

[22] **A:** Inglis, but I use Inglis.

[23] **Q:** My name is Marilena, so I get a

[24] lot of mispronunciations of my name.

[25] **A:** My wife can't figure out which my

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[1] *S. R. INGLIS*

[2] name is, actually.

[3] **Q:** You better tell her.

[4] Who's in the room with you?

[5] **A:** A bunch of lawyers and a court

[6] reporter.

[7] **Q:** Who are the bunch of lawyers?

[8] **A:** Michael Becker, and I'm

[9] forgetting his name, the lawyer for Dr. Stine.

[10] **Q:** I thought I heard you mention Dr.

[11] Loucas.

[12] **A:** He was here. Maybe he left even

[13] before the whole deposition got started.

[14] **Q:** When did you meet with him?

[15] **A:** I met with him yesterday.

[16] **Q:** How long did you and he spend

[17] together?

[18] **A:** About an hour, maybe an hour and

[19] a half.

[20] **Q:** And then today you met with Mr.

[21] Becker?

[22] **A:** With Mr. Becker and Mr. Loucas.

[23] **Q:** Again?

[24] **A:** Again.

[25] **Q:** How much time did you spend

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[1] *S. R. INGLIS*

[2] today?

[3] **A:** 30 minutes, 35 minutes.

[4] **Q:** Have you reviewed any other cases

[5] for Mr. Loucas prior to this case?

[6] **A:** No.

[7] **Q:** For Cathy Loucas or Penny Loucas?

[8] **A:** No.

[9] **Q:** Any other cases for plaintiffs'

[10] lawyers in Northeastern Ohio?

[11] **A:** No.

[12] **Q:** I see that you wrote a report,

[13] and it looks to me sort of like you did a nice

[14] comprehensive review of the materials that

[15] were provided to you prior to reducing your

[16] opinions to writing.

[17] **Yes?**

[18] **A:** I'm sorry, say that again?

[19] **Q:** You wrote a report. At least the

[20] one I have is dated June 7, '04.

[21] Do you have that with you?

[22] **A:** Yes.

[23] **Q:** I think it's been marked as an

[24] exhibit, and it's eight pages of your

[25] opinions.

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[1] *S. R. INGLIS*

[2] **Yes?**

[3] **A:** Yes.

[4] **Q:** And in good fashion as an expert,

[5] it appears to me that you undertook a nice

[6] thorough review of all of the materials

[7] provided to you and then set forth all of the

[8] pertinent opinions that you hold in this case.

[9] **True?**

[10] **A:** I tried my best.

[11] **Q:** And you stand behind your report.

[12] **Yes?**

[13] **A:** Yes.

[14] **Q:** Anything that you wish to add to,

[15] delete from, modify, relative to your report?

[16] **A:** Not at this moment.

[17] **Q:** Let me tell you what we're going

[18] to do.

[19] You've been asked a lot of

[20] questions today. I'm going to ask you some

[21] questions now on behalf of the nurse midwife.

[22] At the conclusion of my questions

[23] or the conclusion of the questions that may be

[24] asked of you by the hospital attorney, if you

[25] have any changes, modifications, deletions to

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[1] make to your report or opinions, I ask that
[2] you make them today; otherwise, we'll rely on
[3] them for trial.
[4] All right?
[5] **A:** If that's okay with Mr. Becker,
[6] yes, I guess.
[7] **Q:** St. Barnabas Ob-Gyn, P.C., what's
[8] that?
[9] **A:** It's a corporation that I run
[10] that employs ten Ob-Gyns and four midwives and
[11] PAs some of the time to do all of the
[12] obstetrics and gynecology up at the hospital.
[13] **Q:** Is it a for-profit organization?
[14] **A:** I think it could theoretically be
[15] a for-profit, but it is definitely part of the
[16] hospital and the hospital is nonprofit.
[17] **Q:** Help me out on that one.
[18] What do you mean theoretically?
[19] **A:** Are you familiar with the term
[20] captive P.C.?
[21] **Q:** Yes.
[22] **A:** That's what it is.
[23] **Q:** Who are the ten OBs you employ?
[24] **A:** They are all general Ob-Gyns, and
[25]

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[1] then the midwives are all certified nurse
[2] midwives.
[3] **Q:** Do you have an affiliation with
[4] Dr. Chirvinack?
[5] **A:** Sure do.
[6] **Q:** Tell me about that.
[7] **A:** I'm still part of the program at
[8] Cornell. I'm an associate professor. I
[9] participate in — I refer cases back and
[10] forth, I go to meetings, discuss. We're good
[11] friends. He was my mentor.
[12] **Q:** That's great.
[13] So you certainly respect what
[14] he's got to say or what he's written.
[15] Right?
[16] **A:** Yes.
[17] **Q:** Very good.
[18] Tell me, sir, are you going to be
[19] providing any criticisms of the nurse midwives
[20] Beregovskaya and Ruzga?
[21] **A:** The way I look at this case is
[22] that the responsibility lies with the Ob-Gyn
[23] or Ob-Gyns plural who are responsible for
[24] those midwives.
[25]

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[1] So, I — I mean, I think there
[2] were some things — for example, I don't think
[3] there was a physical exam documented on the
[4] prenatal care, you know, form or anything like
[5] that, but I think those are relatively minor
[6] in the whole scheme of things.
[7] **Q:** And, so, you would agree with me
[8] that those nurse midwives acted appropriately
[9] in referring this patient for obstetric
[10] consultation on August 21 and on September 5
[11] and on September 8, and to that end you will
[12] not criticize them.
[13] Yes?
[14] **A:** With one exception.
[15] The only thing I'm thinking is
[16] whether they bounced back almost every one of
[17] those prenatal visits. They may have. I'm
[18] wondering whether they actually — when they
[19] saw her 8/21, they certainly bounced it to
[20] them. Whether they saw it again, bounced it
[21] again every single time — as much as
[22] possible, they have to let the physician be
[23] aware of what they're doing. If the physician
[24] thinks it's all right, I don't expect the
[25]

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S. R. INGLIS

[1] midwife to overrule it and admit the patient
[2] for themselves because they're so worried
[3] about the patient.
[4] Did I answer the question?
[5] **Q:** Yes, it does. I think we'll
[6] explore a little further.
[7] With respect to this lawsuit,
[8] sir, did you review what the American College
[9] of Nurse Midwives says about involving and
[10] collaborating with a physician?
[11] **A:** I did not read that.
[12] **Q:** Did you read the Ohio Nurse
[13] Practice Act relative to the role and
[14] responsibility of the nurse midwives in
[15] connection with the collaborating
[16] obstetrician?
[17] **A:** I did not read that document
[18] either.
[19] **Q:** Certainly you know from your
[20] practice, sir, that when you were consulted or
[21] collaborated with by a nurse midwife, you step
[22] in and you do the evaluation as requested of
[23] you.
[24] Yes?
[25]

<p style="text-align: right;">Page 98</p> <p style="text-align: center;">S. R. INGLIS</p> <p>[1]</p> <p>[2] A: Yes, correct.</p> <p>[3] Q: And then once you are consulted</p> <p>[4] and you are collaborating, you undertake in</p> <p>[5] that role of supervising physician as has been</p> <p>[6] requested of you.</p> <p>[7] True?</p> <p>[8] A: Yes.</p> <p>[9] Q: So from August 21 forward, you</p> <p>[10] would agree that nurse midwife Beregovskaya</p> <p>[11] did the appropriate thing in associating with</p> <p>[12] and collaborating with Dr. Bailin, and from</p> <p>[13] that point forward he became responsible for</p> <p>[14] the patient's management.</p> <p>[15] True?</p> <p>[16] A: Do you by any chance know whether</p> <p>[17] they did refer every single time the midwife</p> <p>[18] to them when they're in that clinic?</p> <p>[19] Q: Let me ask you what you've seen</p> <p>[20] and the testimony you've reviewed and your</p> <p>[21] understanding, sir, about the practicalities</p> <p>[22] as relates to the relationship between the</p> <p>[23] nurse midwife and collaborating Ob-Gyn from</p> <p>[24] August 21 forward.</p> <p>[25] Once the call for collaboration</p>	<p style="text-align: right;">Page 100</p> <p style="text-align: center;">S. R. INGLIS</p> <p>[1]</p> <p>[2] True?</p> <p>[3] A: Correct.</p> <p>[4] Q: And, in fact, you know that the</p> <p>[5] patient was asked to call in to see Dr. Bailin</p> <p>[6] once on a repeat visit and failed to do so.</p> <p>[7] Right?</p> <p>[8] A: I don't know that, but...</p> <p>[9] I don't remember that</p> <p>[10] specifically, but if it happened, I'm...</p> <p>[11] Q: Fair enough.</p> <p>[12] Have you sent Mr. Becker or Mr.</p> <p>[13] Loucas a bill for your services to date?</p> <p>[14] A: I believe I did.</p> <p>[15] MS. DISALVIO: Terrific.</p> <p>[16] I'd like a copy of it, please,</p> <p>[17] Mr. Becker. I'd make a formal request</p> <p>[18] for that, please.</p> <p>[19] Q: Dr. Inglis, in connection with</p> <p>[20] your opinions in this case, did you undertake</p> <p>[21] any sort of literature review?</p> <p>[22] A: No.</p> <p>[23] Q: Did you take a look at any of the</p> <p>[24] ACOG technical bulletins or practice</p> <p>[25] bulletins?</p>
<p style="text-align: right;">Page 99</p> <p style="text-align: center;">S. R. INGLIS</p> <p>[1] and consultation was made, Dr. Bailin and/or</p> <p>[2] Dr. Bailin's colleagues became responsible for</p> <p>[3] this patient's primary care and treatment</p> <p>[4] relative to her obstetrical care.</p> <p>[5] True?</p> <p>[6] A: I agree with you.</p> <p>[7] Let me just say one thing,</p> <p>[8] though. The only thing I'm worrying about is</p> <p>[9] whether possibly the patient called the office</p> <p>[10] or something and they didn't refer it back.</p> <p>[11] But the general concept of what you're saying</p> <p>[12] I agree with; on 8/21, clearly the case was</p> <p>[13] not a midwife case anymore, and it became the</p> <p>[14] responsibility of them.</p> <p>[15] My only concern is whether there</p> <p>[16] was any other clear medical issues that they</p> <p>[17] did not forward to the physician. It may not</p> <p>[18] have happened. It's basically —</p> <p>[19] Q: There's certainly none that you</p> <p>[20] can think of as we sit here today?</p> <p>[21] A: Yes, correct.</p> <p>[22] Q: And you don't know of any phone</p> <p>[23] calls that were made by the patient to the</p> <p>[24] office.</p> <p>[25]</p>	<p style="text-align: right;">Page 101</p> <p style="text-align: center;">S. R. INGLIS</p> <p>[1]</p> <p>[2] A: I may have previously at the time</p> <p>[3] when I did this report, but I haven't in the</p> <p>[4] last six months or eight months looked at any</p> <p>[5] of those technical bulletins, no.</p> <p>[6] Q: You're a member of ACOG.</p> <p>[7] Yes?</p> <p>[8] A: Yes.</p> <p>[9] Q: I think you're a fellow.</p> <p>[10] Yes?</p> <p>[11] A: Yes.</p> <p>[12] Q: That's more than a member.</p> <p>[13] Yes?</p> <p>[14] A: No.</p> <p>[15] I think if you're board</p> <p>[16] certified, you get to be a quote/unquote</p> <p>[17] fellow.</p> <p>[18] Q: All right.</p> <p>[19] And you receive the publications</p> <p>[20] of ACOG?</p> <p>[21] A: Yes.</p> <p>[22] Q: You read them and believe them to</p> <p>[23] be reliable.</p> <p>[24] Yes?</p> <p>[25] A: Regarding the prior deposition I</p>

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[1] gave, the thought I had actually on those ACOG
[2] technical bulletins is that I do believe that
[3] they are clearly a bare minimum of what should
[4] be done. I would suggest that that bare
[5] minimum is just that, it's bare minimum. And,
[6] in fact, if you did more than the bare
[7] minimum, that that would be a better standard.

[8] **Q:** What deposition are you talking
[9] about?

[10] **A:** The question when we came up with
[11] the technical bulletin with the definition of
[12] 140 over 90. That's all well and good, and
[13] they put out those numbers and act like those
[14] are numbers I'm supposed to follow.

[15] After thinking about those
[16] questions, I would suggest that those numbers
[17] are there but I would not consider them to be
[18] the best thing for the patients, and every
[19] patient needs to be evaluated very carefully.

[20] **Q:** Let me ask you this question:
[21] You don't think ACOG is publishing literature
[22] that's below the standard of care.

[23] Do you?

[24] **A:** Correct, I would say it's not

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S. R. INGLIS

[1] below the standard of care, no.

[2] **Q:** By the way, have you ever written
[3] to ACOG saying they should change it to 130
[4] over 80?

[5] **A:** You know, there are lots of
[6] people who have their complaints with those
[7] documents. I'm very busy —

[8] **MR. BECKER:** The answer would be
[9] no?

[10] **THE WITNESS:** No.

[11] **Q:** Have you ever written any article
[12] to suggest that the longstanding parameter of
[13] 140 over 90 as making the diagnosis of
[14] hypertension should be changed to conform to
[15] what you believe the definition of
[16] hypertension is?

[17] **A:** If you go into the clinical world
[18] and actually take care of patients, people who
[19] have a blood pressure of 130 over 80, they
[20] will tell you — and this is the majority of
[21] people will tell you — that's not a normal
[22] blood pressure and that needs to be evaluated
[23] and put in the context of the full patient,
[24] and possibly that patient would benefit by

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S. R. INGLIS

[1] more than the minimal care.

[2] **MS. DISALVIO:** Could you read
[3] back my question?

[4] And, sir, I'd like to see if you
[5] can answer it, please.

[6] (Record read)

[7] **A:** First of all —

[8] **MR. BECKER:** Just answer the
[9] question directly.

[10] **A:** No.

[11] **Q:** Are you participating or
[12] conducting or have you sought a grant from a
[13] clinical trial to test out your hypothesis?

[14] **A:** No.

[15] **Q:** I want to go now to the prenatal
[16] record.

[17] And before we do that, did I hear
[18] you correctly that you reviewed Dr.
[19] Stockwell's testimony?

[20] **A:** Yes.

[21] **Q:** You know the book that you were
[22] talking about that had some other reports in
[23] it and the like?

[24] **A:** Yes.

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S. R. INGLIS

[1] **Q:** Where is that book now?

[2] **A:** I think Mr. Loucas has it.

[3] **Q:** Is he with you there?

[4] **A:** No.

[5] He's headed back to Ohio at the
[6] moment, I believe.

[7] **Q:** What else was in that book?

[8] **A:** It was simply expert reports.

[9] **Q:** Are you acquainted with any other
[10] experts in this case?

[11] **A:** Acquainted with Zabuy, and I
[12] think that may be the only one.

[13] **Q:** And certainly you're aware that
[14] Dr. Zabuy is one of the main contributing
[15] authors in terms of references to that ACOG
[16] bulletin on hypertension and pregnancy.

[17] True?

[18] **A:** I believe he may be one of the
[19] contributing authors, yes.

[20] **Q:** And you consider him to be an
[21] authority on hypertensive disorders in
[22] pregnancy.

[23] True?

[24] **A:** I would say that he has his

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[1]
[2] opinion and some people believe and follow
[3] exactly what he does, and some people do much
[4] more; they do additional work to keep their
[5] patients healthy.

[6] **Q:** His opinions are actually in a
[7] big giant book called Hypertensive Disorders
[8] in Pregnancy.

[9] **A:** Correct?

[10] **A:** Correct.

[11] **Q:** Do you own that book?

[12] **A:** I do not.

[13] **Q:** Do you agree with Dr. Stockwell
[14] that the only risk factor that this patient
[15] had as she embarked on her pregnancy was
[16] obesity?

[17] **MR. BECKER:** I'm going to object
[18] to questions based on what Dr. Stockwell
[19] had to say.

[20] You're certainly welcome to ask
[21] him his opinions, but I think it's
[22] inappropriate under 26(b) to inquire
[23] about other people.

[24] **MS. DISALVIO:** You can object,
[25] Mike, but he read Dr. Stockwell's

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S. R. INGLIS

[1] deposition, so I'm going to inquire of
[2] whether he agrees.

[3] **Q:** Do you agree with Dr. Stockwell
[4] that the only risk factor as this patient
[5] embarked on her pregnancy was obesity?

[6] **A:** No.
[7] I believe she had another risk
[8] factor.

[9] **Q:** Which is?

[10] **A:** A blood pressure in the first
[11] twenty weeks of pregnancy of 130 over 80.

[12] **Q:** So, then, I take it you disagree
[13] with Dr. Stockwell that for a diagnosis of
[14] chronic hypertension one needs a blood
[15] pressure of 140 over 90 in the first trimester
[16] on a repetitive basis or several visits.

[17] Would you disagree with that?

[18] **A:** You should add on to that a
[19] history of hypertension when she's not
[20] pregnant, that would be chronic hypertension
[21] — can you read the question back again?

[22] **Q:** Well, yeah, but I'll clarify what
[23] you just said.

[24] There's no history of

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S. R. INGLIS

[1]
[2] hypertension prior to pregnancy for this
[3] patient.

[4] Is there?

[5] **A:** Correct, we don't know whether
[6] she had high blood pressure before she was
[7] pregnant.

[8] **Q:** You don't have any evidence that
[9] she does that I don't have.

[10] Do you, sir?

[11] **A:** No, I don't have any information
[12] about prior to this pregnancy.

[13] There was something else I wanted
[14] to answer in that other question. I had
[15] another thought, and I've lost it.

[16] **Q:** With chronic hypertension, one
[17] needs blood pressures of 140 over 90 in the
[18] first trimester on a repetitive basis; that
[19] is, several visits.

[20] You disagree with that?

[21] **A:** I think I would have given her a
[22] diagnosis of chronic hypertension, and I
[23] believe that these people that took care of
[24] this patient gave her the diagnosis of chronic
[25] hypertension. It's written there.

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S. R. INGLIS

[1] So, I think I'm not the only one
[2] who thinks that blood pressure of 130 over 80
[3] is something that we need to think about and
[4] take into account when we take care of this
[5] patient. So, I would suggest the 130 over 80
[6] is another risk factor.

[7] **MS. DISALVIO:** Can you please
[8] read back my last question and see if
[9] you can give it an answer?

[10] (Record read)

[11] **Q:** Do you disagree with Dr.
[12] Stockwell?

[13] **A:** I would say that if you have a
[14] blood pressure of 140 over 90 repetitively at
[15] less than twenty weeks, that is one of the
[16] definitions that would certainly make you
[17] chronic hypertensive.

[18] We agree.

[19] **Q:** All right.
[20] You agree with Dr. Stockwell that
[21] the management of this patient through and up
[22] until August 21 was entirely appropriate?

[23] **A:** I would say it was okay, yes.

[24] **Q:** You would agree that from the

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[1] **S. R. INGLIS**
[2] hospitalization of August 21, you would agree
[3] with Dr. Stockwell that the only thing that is
[4] a little bit worrisome is the blood pressure
[5] of 144 over 86.
[6] Agreed?
[7] **MR. BECKER:** I'm going to again
[8] object to you quoting Dr. Stockwell to
[9] this doctor.
[10] I think, Marilena, you have a
[11] right to ask him what his opinions are
[12] and the basis of his opinions, but I
[13] think it's inappropriate to ask him if
[14] he agrees with sworn testimony from
[15] another doctor.
[16] Go ahead and give your opinions,
[17] doctor.
[18] **Q:** Actually, my question, sir, is:
[19] Do you agree with Dr. Stockwell, having now
[20] read his deposition, that the only thing a
[21] little worrisome from the August 21 hospital
[22] stay is the blood pressure of 144 over 86?
[23] You agreed with him on that?
[24] **A:** I disagree.
[25] **Q:** Do you agree that a blood

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[1] **S. R. INGLIS**
[2] pressure of 144 over 86 does not a diagnosis
[3] of preeclampsia make?
[4] Do you agree with that with him?
[5] **A:** I would say that a blood pressure
[6] of 144 over 86 is simply a blood pressure. It
[7] doesn't tell you whether it's preeclampsia or
[8] not. It could be preeclampsia, it could not
[9] be preeclampsia. It doesn't tell you whether
[10] it is or not.
[11] **Q:** You would agree that a diagnosis
[12] of preeclampsia cannot be made based upon a
[13] blood pressure of 144 over 86.
[14] True?
[15] **A:** You can make the diagnosis of
[16] preeclampsia if you have a blood pressure of
[17] 144 over 86 and you have other things wrong
[18] with you, yes.
[19] **Q:** That wasn't my question.
[20] **A:** I know.
[21] **Q:** Blood pressure of 144 over 86
[22] does not make a diagnosis of preeclampsia.
[23] True?
[24] **A:** Simply one blood pressure of 144
[25] over 86 by itself does not give you

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[1] **S. R. INGLIS**
[2] preeclampsia.
[3] **Q:** One plus proteinuria is not
[4] particularly significant.
[5] Do you agree with Dr. Stockwell
[6] in that regard?
[7] **A:** If we're going to go through the
[8] same line of questions over and over again,
[9] one plus protein and one dip stick doesn't
[10] give you preeclampsia. It takes more than
[11] that to make the diagnosis. It takes more
[12] work.
[13] **Q:** You don't have to get angry. I'm
[14] just trying to ask you your opinions.
[15] You would agree with me with
[16] respect to one plus proteinuria, a 24-hour
[17] urinalysis will likely not demonstrate
[18] significant protein in the urine?
[19] **A:** It depends on the definition of
[20] significant.
[21] **Q:** What's your definition of
[22] significant?
[23] **A:** Certainly anything over 300
[24] milligrams.
[25] **Q:** What do you believe is needed on

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[1] **S. R. INGLIS**
[2] qualitative analysis to achieve what you think
[3] is significant at 300 milligrams?
[4] **A:** I'm not sure.
[5] It's all statistically done. I
[6] mean, you could — you could have a dip stick
[7] of only one plus and end up with more than 300
[8] milligrams; so, therefore, I would suggest
[9] that one be careful and check the 300
[10] milligrams, make sure it's not 300 milligrams.
[11] I don't think it's zero.
[12] **Q:** You're certainly aware of the
[13] literature that would suggest that
[14] qualitatively it's a plus two or plus three
[15] that will likely correlate with proteinuria on
[16] a 24-hour urine specimen, not plus one.
[17] You're aware of that literature?
[18] **A:** The key word here is likely.
[19] **Q:** That's what we're interested in
[20] here.
[21] **A:** Likely is a good word, but
[22] generally in medicine we try to be sure. And
[23] if there's any doubt, you might want to
[24] consider doing the test to make sure.
[25] **MS. DiSALVIO:** Madam court

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[1] **S. R. INGLIS**
[2] reporter, can you read my question
[3] back?
[4] (Record read)
[5] **Q:** Are you aware of that literature,
[6] sir?
[7] **A:** I'm aware of it, yes.
[8] **Q:** Do you disagree with it?
[9] **A:** No, I don't disagree with it.
[10] **Q:** Are you at all surprised that the
[11] literature suggests that where a urinalysis is
[12] negative for protein — a 24-hour urinalysis
[13] will likely be negative for protein?
[14] **A:** I'm not surprised by that.
[15] **Q:** Are you aware of that literature?
[16] **A:** Not specifically, no, but it
[17] would not surprise me.
[18] **Q:** You disagree with that
[19] proposition?
[20] **A:** No, I do not disagree.
[21] **Q:** Would you agree with me that
[22] prior to the September 16, 17 admission, Ms.
[23] McElfish's cervix was unripe?
[24] **A:** I believe that to be the case,
[25] yes.

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[1] **S. R. INGLIS**
[2] **Q:** Do you agree with me that there
[3] was never any evidence of fetal compromise in
[4] this case?
[5] **A:** Yes, I agree with that.
[6] **Q:** Do you agree with me that there
[7] was no evidence of maternal end organ
[8] involvement in the prenatal assessment and
[9] management of this patient?
[10] **A:** Could you repeat the question?
[11] **Q:** I sure could.
[12] Would you agree with me that
[13] there was no evidence of maternal end organ
[14] involvement throughout this patient's prenatal
[15] course?
[16] **A:** The only one I'm debating, on 9/8
[17] there's a two plus protein, and I guess it
[18] depends on your definition of end organ.
[19] **Q:** What's your definition of end
[20] organ?
[21] **A:** Clearly, liver would be
[22] included. Clearly, hematological problems
[23] would be included.
[24] Kidneys, I think classically are
[25] an end organ. They're an organ that gets

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[1] **S. R. INGLIS**
[2] damaged. So, if you want to include kidneys,
[3] then maybe that is one of them.
[4] **Q:** Do you include it?
[5] **A:** Yes.
[6] **Q:** You would agree with me that
[7] there is no evidence whatsoever of kidney
[8] function abnormality in the prenatal period by
[9] way of BUN or creatinine.
[10] True?
[11] **A:** No, false.
[12] I already testified that I
[13] thought eleven for BUN was not normal.
[14] **Q:** Okay. Let's go back there for a
[15] minute.
[16] What's the lab reference range
[17] for the BUN you claim to be abnormal?
[18] **A:** That won't be for pregnancy, it
[19] will be for someone forty years old and not
[20] pregnant.
[21] **Q:** So, as I understand it, you
[22] believe that the reference range for the BUN
[23] for Sherry McElfish applies to a forty year
[24] old not pregnant individual?
[25] **A:** It applies to the standard

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[1] **S. R. INGLIS**
[2] persons that are not pregnant.
[3] **Q:** Can you tell me literature that
[4] says BUN of eleven is abnormal for
[5] proteinuria?
[6] **A:** I can't.
[7] **Q:** Do you know of any?
[8] **A:** No.
[9] **Q:** Then based upon the principals in
[10] the literature and in the ACOG technical and
[11] practice bulletins, would you agree with me
[12] that Sherry McElfish did not have any evidence
[13] of kidney end organ dysfunction based on BUN
[14] and creatinine in the prenatal period?
[15] **MR. BECKER:** Objection.
[16] Asked and answered.
[17] **A:** According to those documents you
[18] just listed, I guess it's not in there.
[19] **Q:** So I would be correct.
[20] Yes?
[21] **A:** For those specific documents,
[22] yes.
[23] **Q:** Do you agree with me that this
[24] patient had an amniotic fluid embolus?
[25] **A:** No.

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[1] **S. R. INGLIS**
[2] **Q:** Did you review the autopsy
[3] protocol?
[4] **A:** I did a long time ago.
[5] **Q:** Do you have it in your materials?
[6] **A:** Maybe.
[7] **Q:** Why don't you take a look for
[8] it?
[9] **A:** I think I do.
[10] Yes, I have it in front of me.
[11] **Q:** I want to jump back for a
[12] moment.
[13] We only addressed the kidney.
[14] You agree with me that this patient had no
[15] other end organ involvement in her prenatal
[16] course.
[17] True?
[18] **A:** She frequently complained of
[19] headache, lights and stars, and so on. So,
[20] possibly she had neurological symptoms,
[21] possibly that is an end organ.
[22] **Q:** I beg your pardon?
[23] Is it your testimony that she had
[24] neurologic involvement?
[25] **A:** Well, on 8/21 she complains of

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[1] **S. R. INGLIS**
[2] headache, visual symptoms, flashing lights and
[3] stars, while her blood pressure is 150 over
[4] 100. So, there's neurological symptoms. I
[5] don't know whether you would call those end
[6] organ.
[7] Did you refer to end organ
[8] damage? Involvement?
[9] So, I'm not sure.
[10] **Q:** When we're talking end organ, do
[11] you believe that those are symptoms of brain
[12] end organ involvement?
[13] Is that your testimony?
[14] **A:** I'm not sure whether they would
[15] fit the definition. They might be an end
[16] organ. I don't know.
[17] They certainly are not — it just
[18] depends on your definition of the brain, and
[19] then whether simply vasospasm would be an end
[20] organ involvement. It might be.
[21] **Q:** Can you cite me to any literature
[22] to support that?
[23] **A:** No, I can't.
[24] **Q:** Would you agree with me that in
[25] all likelihood those symptoms do not represent

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[1] **S. R. INGLIS**
[2] brain end organ involvement?
[3] **A:** Well, they certainly are part of
[4] the definition of severe preeclampsia, and we
[5] certainly take it very seriously, so maybe I
[6] should say they are end organ involvement and
[7] you need to deliver.
[8] Maybe they are. I don't know the
[9] answer as to whether they are according to
[10] definition of an end organ. I don't know.
[11] **Q:** Are you familiar with the ACOG
[12] expert witness affirmation?
[13] **A:** Yes.
[14] **Q:** Are you familiar with that
[15] document?
[16] **A:** Yes.
[17] **Q:** Are you willing to sign that
[18] document in connection with the opinions that
[19] you're giving here today and have your
[20] opinions peer reviewed by members of the
[21] American College?
[22] **A:** I don't know.
[23] **Q:** You don't know what, sir?
[24] **A:** I don't know what that has to do
[25] with this discussion.

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[1] **S. R. INGLIS**
[2] **Q:** Are you willing to have the
[3] opinions that you're giving here today
[4] reviewed by your peers in the American College
[5] of Obstetrics — of Obstetricians and
[6] Gynecologists?
[7] **A:** They probably are able to right
[8] now.
[9] **Q:** Are you willing to submit them
[10] for review?
[11] **A:** I don't have any choice; you can
[12] submit them whenever you want.
[13] **Q:** Are you willing to sign an
[14] affirmation relative to your opinions?
[15] **A:** I have to think about it.
[16] **Q:** Very good.
[17] You were looking at the autopsy.
[18] Can you look at the lung
[19] assessment for me?
[20] **A:** I don't see it.
[21] Do you know what page it's on?
[22] **Q:** If you don't have it, tell me you
[23] don't have it. That's fine too.
[24] **A:** Yes, I actually see it now on
[25] page three.

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S. R. INGLIS

- [1]
[2] **Q:** Are there any findings there that
[3] indicate amniotic fluid embolus?
[4] **A:** It says trophoplastic emboli.
[5] **Q:** What does that suggest to you?
[6] **A:** It suggests the pathologist that
[7] did the autopsy thinks there may have been
[8] trophoplastic emboli.
[9] **Q:** That's an amniotic fluid embolus.
[10] Yes?
[11] **A:** No.
[12] **Q:** So you would disagree with Dr.
[13] Stockwell, who states that there is, indeed,
[14] evidence of amniotic fluid embolism based upon
[15] precisely what you just read.
[16] You disagree with him in that
[17] regard?
[18] **A:** I believe that we only have
[19] trophoplastic emboli, and that does not equal
[20] amniotic fluid embolism as in a clinical
[21] disorder.
[22] **Q:** So, you would disagree with Dr.
[23] Stockwell.
[24] Yes?
[25] **A:** Yes.

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S. R. INGLIS

- [1]
[2] **Q:** Do you agree that one is unable
[3] to predict or prevent an amniotic fluid
[4] embolus?
[5] **A:** Yes.
[6] **Q:** Do you agree that difficult
[7] breathing and a sudden drop in blood pressure
[8] are consistent with a diagnosis of amniotic
[9] fluid embolism?
[10] **A:** Yes.
[11] **Q:** Do you agree that amniotic fluid
[12] embolus is the leading cause of death during
[13] labor and the several hours postpartum?
[14] **A:** No.
[15] **Q:** Do you rule out amniotic fluid
[16] embolism as causing or contributing to Sherry
[17] McElfish's death?
[18] **A:** No, I don't rule it out.
[19] **Q:** Do you agree that the development
[20] of superimposed preeclampsia is common in
[21] patients with hypertension and often difficult
[22] to diagnose?
[23] **A:** Yes.
[24] **Q:** Do you agree that women with mild
[25] hypertension as defined by 140 to 179 over 90

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S. R. INGLIS

- [1]
[2] to 109 generally do well during pregnancy and
[3] do not require anti-hypertensive medication?
[4] Do you agree with that?
[5] **A:** Could you say it one more time?
[6] **Q:** Women with mild hypertension as
[7] defined systolic 140 to 179, diastolic 90 to
[8] 109, generally do well during pregnancy and as
[9] a rule do not require anti-hypertensive
[10] medication.
[11] Do you agree with that?
[12] **A:** I would suggest that patients
[13] with blood pressure over 160 systolic and
[14] diastolic over 105 may benefit from
[15] hypertensive therapy, but the rest of it I
[16] agree with.
[17] **MS. DISALVIO:** Do you need to
[18] take a break?
[19] **THE WITNESS:** Yes, can I?
[20] (Recess taken)
[21] **Q:** Doctor, I want to jump back to
[22] September 5 for a minute.
[23] Do you agree while the patient
[24] was in hospital on September 5 that all labs
[25] were normal, blood pressures were normal, and

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S. R. INGLIS

- [1]
[2] there was negative urine protein?
[3] Do you agree with that?
[4] **A:** Yes.
[5] **Q:** Do you agree that there is no
[6] data, no scientific evidence, that
[7] anti-hypertensive medication will improve
[8] perinatal outcome?
[9] **A:** Yes, I do agree with that.
[10] **Q:** Do you agree that the majority of
[11] pregnant women with chronic hypertension have
[12] uncomplicated hypertension and can be managed
[13] the same as normal nonhypertensive women
[14] during the intrapartum period?
[15] **A:** Could you state that one more
[16] time for me?
[17] **Q:** Sure.
[18] Do you agree that the majority of
[19] pregnant women with chronic hypertension have
[20] uncomplicated hypertension and can be managed
[21] the same as normal nonhypertensive women
[22] during the intrapartum period?
[23] **A:** Does the majority mean greater
[24] than fifty percent?
[25] **Q:** Yes.

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[1] **S. R. INGLIS**
[2] A: Yes, then.
[3] Q: Are you licensed to practice
[4] medicine?
[5] A: Yes.
[6] Q: Do you spend greater than fifty
[7] percent of your time in the active clinical
[8] practice of medicine or its teaching?
[9] A: Yes.
[10] MS. DISALVIO: I'm going to pass
[11] the baron to my colleagues and see if
[12] they have any other questions while I
[13] review my notes.
[14] **EXAMINATION**
[15] **BY MS. REID:**
[16] Q: My name is Christine Reid, and I
[17] represent Euclid Hospital in this case and
[18] just have a couple of questions for you.
[19] First of all, I think we
[20] established that in your opinion a blood
[21] pressure of 130 over 80 is not a normal blood
[22] pressure for a pregnant patient.
[23] Correct?
[24] A: Yes.
[25] Q: What is your definition of a

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[1] **S. R. INGLIS**
[2] normal blood pressure during pregnancy?
[3] A: Probably 120 over 70 would be
[4] normal.
[5] It really depends on the age of
[6] the patient. If she is 16 and you have a
[7] blood pressure of even 120, that's
[8] questionable; if she's 45, then that might be
[9] normal for her.
[10] Q: Let's say in a 27 year old
[11] patient, what's a normal blood pressure during
[12] pregnancy?
[13] A: I would say a normal would be 120
[14] over 70. It wouldn't raise a flag for me to
[15] do anything special.
[16] Q: If a patient has a blood pressure
[17] of higher than 120 over 70, is that in your
[18] practice given a work-up for preeclampsia?
[19] A: No, I don't think it has to.
[20] I think it needs to be monitored
[21] carefully and it has to be considered that if
[22] you have any further trouble with her blood
[23] pressure, that she will need a work-up for
[24] chronic hypertension just to make sure there's
[25] nothing wrong with her kidneys to get a

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[1] **S. R. INGLIS**
[2] baseline.
[3] Q: At what point would you get this
[4] baseline study, then?
[5] A: You're talking now specifically
[6] this case?
[7] Q: No, I'm talking about in your
[8] practice with the 27 year old patient who
[9] initially presents with a blood pressure above
[10] 120 over 70.
[11] A: Right.
[12] I think it would be reasonable to
[13] leave her alone and not do it when she first
[14] does —
[15] You want to make it a blood
[16] pressure of 130 over 80, is that the number
[17] you want to pick?
[18] It might be easier to do it that
[19] way.
[20] Q: Sure.
[21] A: In that case, then I think it
[22] would be reasonable to not do a work-up the
[23] first time you get a 130 over 80, but I would
[24] suggest the — when you continue the
[25] pregnancy, you watch the blood pressure. And

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[1] **S. R. INGLIS**
[2] if the blood pressure starts to climb even
[3] higher, then I would suggest at some point you
[4] need to do a baseline work-up to see how the
[5] patient's doing. And then you could use that
[6] later on in pregnancy to determine whether
[7] she's, indeed, developing preeclampsia or
[8] whether she has a baseline renal problem or
[9] renal disease.
[10] Q: Doctor, it seems to me in
[11] listening to your testimony and reviewing your
[12] report that your criticisms of the care and
[13] the care providers in this case end at about
[14] 2:30 a.m. on the 17th.
[15] Is that correct?
[16] A: I don't know how to answer that
[17] question. Tell me what you mean by that
[18] question.
[19] Q: Well, do you have any criticisms
[20] of any care that was provided after 2:30 a.m.
[21] on September 17 — or is it September 18?
[22] No, September 17, I apologize.
[23] A: Well, I think that she at 2:30
[24] needed everything that she needed earlier.
[25] She still needed to be under very intensive

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S. R. INGLIS

[1]
[2] monitoring, most likely in an intensive care
[3] unit setting where they can do everything, and
[4] check labs very frequently, et cetera.
[5] **Q:** Is it fair to say now that you've
[6] been questioned by everyone in this case that
[7] we've covered either through your report or
[8] deposition testimony all of your opinions in
[9] this case?
[10] **A:** I think we have, yes.
[11] **Q:** Have you ever been sued for
[12] medical malpractice, Dr. Inglis?
[13] **A:** Yes.
[14] **Q:** On how many occasions?
[15] **A:** It must be two, but I clearly
[16] have been sued at least once.
[17] **Q:** What county were those lawsuits
[18] in?
[19] **A:** It's in the City of Albany in New
[20] York.
[21] **Q:** Both of them?
[22] **A:** Actually, I can remember better
[23] now. There was one suit in Albany, and there
[24] was — then I was dismissed from — no,
[25] there's only one that I can clearly tell you,

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S. R. INGLIS

[1] and that's in Albany where I was sued.
[2] **Q:** About what year was that?
[3] **A:** That would have been 19 —
[4] probably 1989.
[5] **MS. REID:** That's all the
[6] questions I have. Thank you.
[7] **MS. DiSALVIO:** I have more when
[8] everybody's done.
[9] **MR. AUCIELLO:** I have no further
[10] questions.
[11] **MS. DiSALVIO:** Ernie, do you have
[12] any more?
[13] **MR. AUCIELLO:** No, I'm done.

**EXAMINATION
BY MS. DiSALVIO:**

[14] **Q:** Doctor, I just have one last one.
[15] In your report, you set forth
[16] your criticisms, if I'm correct, at pages
[17] five, six, seven, and eight.
[18] Yes?
[19] **A:** Yes.
[20] **Q:** And in those criticisms, you have
[21] not articulated any criticisms relative to the
[22] assessment or the confinement of September 5.

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S. R. INGLIS

[1] True?
[2] **A:** I think it was implicit that the
[3] same remarks regarding 8/21 would apply to
[4] 9/5.
[5] **Q:** It's not in your report.
[6] True?
[7] **A:** It may not be there.
[8] **Q:** Take a moment. Point it out to
[9] me if it's there.
[10] **MR. BECKER:** It's on page six,
[11] paragraph eight.
[12] **MS. DiSALVIO:** I'm sorry, who's
[13] talking?
[14] **MR. BECKER:** Mike is talking.
[15] **MS. DiSALVIO:** What did you say?
[16] **MR. BECKER:** I said page six,
[17] paragraph eight.
[18] **MS. REID:** Is that the answer to
[19] the question?
[20] **MR. BECKER:** I'm trying to move
[21] it along.
[22] I understand the question is:
[23] Did you reference 9/5 at any time?
[24] **Q:** Actually, the question is: Did
[25]

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S. R. INGLIS

[1] you reference the confinement and evaluation
[2] in the hospital of September 5 in your report?
[3] **A:** Possibly, yes.
[4] If you look at number eight, it
[5] says no effort was made to rule in or rule out
[6] superimposed preeclampsia from 9/5 to 9/16 in
[7] terms of doing 24-hour urine or bloodwork to
[8] check platelets or liver function.
[9] **Q:** Let's go to September 5.
[10] You reviewed the admission?
[11] **A:** Yes.
[12] **Q:** And I think you've already agreed
[13] with me that the urinalysis was negative for
[14] protein during that confinement.
[15] **A:** I believe, yes.
[16] **Q:** All blood pressures obtained
[17] during that confinement were normal.
[18] Correct?
[19] **A:** Yes.
[20] **Q:** Feel free to look.
[21] **A:** You're right.
[22] **Q:** And some labs were done.
[23] Yes?
[24] **A:** Yes.
[25]

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[1] **S. R. INGLIS**
[2] Q: And those labs were normal?
[3] A: Correct.
[4] Q: What labs were done?
[5] A: I believe — I'm sure liver
[6] functions were done, uric acid were done.
[7] I'm not sure if a CBC was done
[8] that day.
[9] Q: The labs you say should have been
[10] done were, indeed, done on this date?
[11] A: Well, no.
[12] The statement that you're reading
[13] is a generic statement, and, so, it's saying
[14] that —
[15] Q: I can't hear you.
[16] A: The statement you're reading here
[17] is a generic statement saying there was no
[18] 24-hour urine done on any of those occasions.
[19] Q: I want to talk about September 5
[20] and my client Dr. Karasik.
[21] You don't have criticisms of the
[22] way Dr. Karasik managed and evaluated this
[23] patient for his limited contact in hospital on
[24] September 5.
[25] True?

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[1] **S. R. INGLIS**
[2] A: Let me make sure it's clear.
[3] Dr. Karasik was, like, the house
[4] physician doing the nonstress test or the
[5] person who was responsible for that patient?
[6] Q: On September 5, he was the
[7] physician who was attending to the patient in
[8] hospital.
[9] You would agree with me that he
[10] obtained the appropriate lab studies.
[11] True?
[12] A: Did Dr. Karasik refer the patient
[13] in from the clinic to the hospital.
[14] Q: No.
[15] A: Someone else did?
[16] Q: He was the receiving physician at
[17] the hospital.
[18] A: Right.
[19] Did he work with Dr. Bailin?
[20] Is he one of his partners?
[21] Q: Does it matter to you, sir?
[22] A: Yes.
[23] Q: Why?
[24] A: Because whoever referred in the
[25] patient is the one who makes the decisions as

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[1] **S. R. INGLIS**
[2] to what exactly — how they want that patient
[3] evaluated. If Dr. Karasik is simply the
[4] person in there doing nonstress tests and
[5] checking the blood pressure, then I think his
[6] care was fine.
[7] But whoever referred the patient
[8] in from the clinic with a blood pressure of
[9] 160 over 86 should have requested more work be
[10] done.
[11] Did I answer the question?
[12] Q: Yes.
[13] What additional work?
[14] A: Admit to the hospital for at
[15] least 24 hours, check the blood pressure, do a
[16] 24-hour urine, do the labs that they did and
[17] maybe repeat the labs that they did, and, if
[18] the blood pressure was still high, keep her in
[19] the hospital.
[20] Q: And if the blood pressure was
[21] normal, the 24-hour urine was normal, and the
[22] labs are normal, it's appropriate to
[23] discharge.
[24] Yes?
[25] A: If all of the subsequent blood

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[1] **S. R. INGLIS**
[2] pressures were normal, and, as you say, all
[3] the laboratory work was done and was normal,
[4] then you could consider discharge. She would
[5] need very careful follow-up in terms of her
[6] blood pressure because just earlier that
[7] morning she had a very high blood pressure,
[8] but she could be discharged.
[9] MS. DISALVIO: Of course she
[10] could.
[11] Okay. I don't think I have any
[12] other questions.
[13] MR. TREU: Nothing here.
[14]
[15] (Time noted: 5:15 p.m.)
[16]
[17]
[18]
[19]
[20]
[21]
[22]
[23]
[24]
[25]

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CAPTION

[1]
[2]
[3]
[4] The Deposition of STEVEN R. INGLIS, M.D.,
[5] taken in the matter, on the date, and at the
[6] time and place set out on the title page
[7] hereof.
[8]
[9]
[10] It was requested that the deposition be taken
[11] by the reporter and that same be reduced to
[12] typewritten form.
[13]
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CERTIFICATE

**STATE OF :
COUNTY/CITY OF :**

[1]
[2]
[3]
[4]
[5]
[6]
[7] Before me, this day, personally appeared
[8] STEVEN R. INGLIS, M.D., who, being duly sworn,
[9] states that the foregoing transcript of his
[10] Deposition, taken in the matter, on the date,
[11] and at the time and place set out on the title
[12] page hereof, constitutes a true and accurate
[13] transcript of said deposition.
[14]
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[18]
[19]
[20]
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[24]
[25]

STEVEN R. INGLIS, M.D.

SUBSCRIBED and SWORN to before me this
day of , 2005, in the jurisdiction
aforesaid.

My Commission Expires Notary Public

**DEPOSITION ERRATA SHEET
RE:**

FILE NO. 465040

CASE CAPTION: McELFISH v. MERIDIA, et al.

DEPONENT: STEVEN R. INGLIS, M.D.

DEPOSITION DATE: FEBRUARY 17, 2005

To the Reporter:

[7] I have read the entire transcript of my
Deposition taken in the captioned matter or
[8] the same has been read to me. I request for
the following changes to be entered upon the
[9] record for the reasons indicated.
I have signed my name to the Errata Sheet and
[10] the appropriate Certificate and authorize you
to attach both to the original transcript.
[11]
[12]
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SIGNATURE: DATE:

STEVEN R. INGLIS, M.D.

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[1]
[2] CERTIFICATE
[3] STATE OF NEW YORK)
[4])ss.:
[5] COUNTY OF NEW YORK)
[6] I, LINDA A. MARINO, a Registered
[7] Professional Reporter, Certified
[8] Shorthand Reporter, and Notary Public
[9] within and for the State of New York do
[10] hereby certify:
[11] I reported the proceedings in the
[12] within-entitled matter to the best of my
[13] ability, and that the within transcript
[14] is a true record of such proceedings.
[15] I further certify that I am not
[16] related, by blood or marriage, to any of
[17] the parties in this matter and that I am
[18] in no way interested in the outcome of
[19] this matter.
[20] IN WITNESS WHEREOF, I have
[21] hereunto set my hand this day of
[22] 2005.
[23]
[24]
[25] LINDA A. MARINO, RPR, CSR

Lawyer's Notes

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