**In The Matter Of:**

*MCELFISH v.*
*MERIDIA MEDICAL*

---

*STEVEN INGLIS*
*February 17, 2005*

---

*FINK & CARNEY REPORTING AND VIDEO SERVICES*
*39 WEST 37TH STREET*
*NEW YORK, NY USA 10018*
*(212) 869-1500 or (800) 692-3465*

*Original File 021705PM.TXT, 142 Pages*
*Min-U-Script® File ID: 0411271050*

**Word Index included with this Min-U-Script®**

IN THE COURT OF COMMON PLEAS
STATE OF OHIO
COUNTY OF CUYAHOGA

KARL McELFISH, II, Admin., etc.,

Plaintiff,

Case No.
-against- 465040

MERIDIA MEDICAL GROUP, et al.,

Defendants.

February 17, 2005
2:18 p.m.

Deposition of STEVEN R. INGLIS, M.D., taken by Defendants, at the office of Fink & Carney, 39 West 37th Street, New York, New York, before Linda A. Marino, Registered Professional Reporter, Certified Shorthand Reporter, and Notary Public within and for the State of New York.



Appearances:

BECKER & MISHKIND CO., L.P.A.
Attorneys for Plaintiffs
134 Middle Avenue
Elyria, Ohio 44035

BY: MICHAEL F. BECKER, ESQ.

-AND-

GEORGE E. LOUCAS, CO., L.P.A.
250 Spectrum Office Building
6060 Rockside Woods Boulevard
Independence, Ohio 44131-7300

BY: GEORGE E. LOUCAS, ESQ.

GALLAGHER SHARP FULTON & NORMAN
Attorneys for Defendant
Lucille Stine, M.D.
Seventh Floor, Bulkley Building
1501 Euclid Avenue
Cleveland, Ohio 44115

BY: ERNEST W. AUCIELLO, JR., ESQ.

MOSCARINO & TREU, L.L.P.
Attorneys for Defendant
Charles M. Baillin, M.D.
630 Hanna Building
1422 Euclid Avenue
Cleveland, Ohio 44115

BY: KRIS TREU, ESQ.
(via videoconference)

(continued on next page)

Appearances(continued):

REMINGER & REMINGER
Attorneys for Defendants
Meridia Medical Group, Gregory Karasik, M.D., and Yelena Beregovskaya, R.N.
1400 Midland Building
101 Prospect Avenue, West
Cleveland, Ohio 44115-1093

BY: MARILENA DiSALVIO, ESQ.
STEPHEN E. WALTERS, ESQ.
(via videoconference)

REMINGER & REMINGER
Attorneys for Defendant
Meridia Euclid Hospital
1400 Midland Building
101 Prospect Avenue, West
Cleveland, Ohio 44115-1093

BY: CHRISTINE S. REID, ESQ.
(via videoconference)





(Prior to the start of the deposition, Curriculum vitae was marked Exhibit 1 for identification; and 6/7/04 Report was marked Exhibit 2 for identification.)

STEVEN R . INGLIS, having been first duly sworn by a Notary Public of the State of New York (Linda A. Marino), was examined and testified as follows:

**EXAMINATION**

**BY MR. AUCIELLO:**

**Q:** Would you please state your name for the record, please?

**A:** Steven Inglis.

**Q:** Doctor, have you ever been deposed before?

**A:** Yes.

**Q:** About how many times?

**A:** Two times.

**Q:** I'll go over some of the ground rules.

It's basically simple.This is





just a question-and-answer session under oath. I am taking your deposition, as are the other attorneys by videoconferencing, because you've been identified as an expert for the Plaintiff in this case.

If you don't understand any question I ask you, I would ask that you tell me that so I can rephrase it. Otherwise, I'll end up assuming that you understood the question.

Is that fair?

**A:** Yes.

**Q:** It's also important so we have an accurate record that you give verbal responses to all my questions, as opposed to nods of the head or nonverbal signals because the court reporter can't take those down.

Fair?

**A:** Yes.

**Q:** Doctor, I will ask you under what circumstances were you deposed those two other times?

**A:** I believe I've been deposed twice as an expert witness.

Q: As an expert.
When was the last time you were deposed?
A: Probably two years ago.
Q: Do you remember the name of the case?
A: I do not.
Q: Do you remember where that case was situated?
A: New York.
Q: In New York.
Do you remember who you were a witness for?
A: No.
Q: Do you remember the general subject matter of that case?
A: I do not.
Q: What about the other deposition?
A: That deposition was many years ago.
Q: Were you also an expert in that case?
A: Yes.
Q: Do you remember the name of that





case?
A: Do not.
Q: Do you remember the general subject matter of that case?
A: Shoulder dystocia.
MR. TREU: Ernie, excuse me.
Can you keep your voice up?
I'm having a hard time hearing you.
MR. AUCIELLO: All right.
Q: That was a shoulder dystocia case, the one you were involved in many years ago?
A: Yes.
Q: Do you remember if you were expert for the plaintiff or the defendant?
A: Plaintiff.
Q: Are those the only two depositions you've given in your life?
A: I'm not sure of the definition of deposition. I've certainly been as a witness to cases and things like that, but I think — is that a deposition?
Q: Any time that you've given





testimony under oath in front of a court reporter.
A: Oh, then it's more than that.
Q: About how many times?
A: Probably four, total.
Q: Tell me about the other two that we haven't talked about.
A: One of them was a case where I was not named but a witness, and they wanted me to come in and help.
Q: You were a fact witness in a medical malpractice case?
A: Correct.
Q: And what about the fourth one?
A: I'm just guessing there must be one other time I've been.
Q: Have you ever been named a defendant in a medical negligence case?
A: Yes.
Q: Were you deposed in that case?
A: No.
Q: And what happened with that case?
A: I was dropped out of it.
Q: Do you remember the subject





matter of that case?
A: Fetal distress.
Q: And you were dismissed without payment?
A: Correct.
Q: And that was here in New York?
A: Yes.
Q: Doctor, what's your present professional address?
A: St. Barnabas Hospital, 4422 Third Avenue, Bronx, New York.
Q: And who is your employer?
A: St. Barnabas Ob-Gyn, P.C.
Q: So, you work for a physician group?
A: I run the physician group.
Q: You're president of that organization?
A: Yes.
Q: Do you have any employment other than your employment with that organization?
A: No.
Q: How long have you been with St. Barnabas — the St. Barnabas organization

you've mentioned?
A: Eight years.
Q: I've directed to be put before you your CV and a report. I don't know which is — the CV is marked as Exhibit 1.
Is that a true and accurate copy of your curriculum vitae?
A: Yes.
Q: Is it reasonably up to date?
A: Yes.
Q: And Exhibit 2, is that a true and accurate copy of the written report you provided to Mr. Becker concerning this case?
A: As far as I can see, yes, it looks like the same thing, yes.
Q: Did you do any other reports, other than that one?
A: No.
Q: Okay.
Doctor, at what hospitals do you presently have privileges?
A: St. Barnabas Hospital and New York Presbyterian-Cornell.
Q: How would you describe the nature





of your practice?
A: It is obstetrics, gynecology, and high risk obstetrics.
Q: Can you give me a breakdown between obstetrics and gynecology?
Is it 50/50? 60/40?
A: Obstetrics would be 90 percent for me.
Q: Okay.
Other members of your group may differ?
(Whereupon, Ms. Reid, Mr. Walters, and Ms. DiSalvio joined the videoconference.)
MR. TREU: Hold on. We have new attendees.
(Pause in proceedings).
Q: Doctor, I think you just told us your practice is 90 percent obstetrics and 10 percent gynecology?
A: Yes.
Q: And the others in your group may vary?
A: Generally 50 percent for the rest





of the group.
Q: Do you have a subspecialty?
A: I am a maternal-fetal medicine specialist.
Q: Any particular area of interest within maternal-fetal medicine?
A: Preterm delivery.
Q: Is it true that the major thrust of your research has been the cause of preterm delivery?
A: Yes.
Q: Doctor, directing your attention to the curriculum vitae, it lists a number of publications.
I don't want to go through them all, but can you identify for us any of the publications you have in that CV that may be relevant to the issues in this case?
A: One that may be possibly relevant would be — doesn't have a number next to it — the article that was entitled: When should twins be delivered?
Q: Okay.
A: That's it.





Q: So I don't forget to come back to it, what about that article that is entitled: When should twins be delivered?, what about that article makes it relevant to this case?
A: Well, I think in that article you will be able to see that part of our job is to determine when is the best time to deliver twins. And it's not any different than any patient who has blood pressure problems in pregnancy. It's the same issue of concern and the thought process that needs to go into the decision as to when those babies should be delivered, and twins.
Q: Regardless of when — it applies when there's not twins as well?
A: Correct.
Q: Doctor, do you have any present teaching responsibilities?
A: Yes.
I teach medical students and residents at St. Barnabas Hospital, and I teach residents at Cornell as well.
Q: Do you have a title at Cornell?
A: I'm an associate professor of

obstetrics and gynecology.

**Q:** Do you have any administrative roles at either the hospital or the university?

**A:** No administrative role at the university.

At St. Barnabas Hospital, I'm in charge of the department of Ob-Gyn and basically take care of a big department of Ob-Gyns and midwives, and, to a certain extent, have to monitor the nursing as well inside of the hospital.

**Q:** About what percentage of your professional time is consumed by the administrative role you have to have at the hospital?

**A:** I would say fifteen percent is administrative.

**Q:** You also have — you're president of your practice, your own practice, the St. Barnabas group?

**A:** Yes.

**Q:** How much of your time is occupied by that job?





**A:** I'm including that in the fifteen percent.

**Q:** Other than teaching students at Cornell and St. Barnabas and your practice at St. Barnabas and New York Presbyterian through your company, is that the entirety of your medical practice right now?

**A:** Yes.

**Q:** And how long has it been substantially the same?

**A:** For eight years.

**Q:** Eight years?

**A:** Yeah.

**Q:** You haven't had privileges at different hospitals, it's all been the same?

**A:** I did have privileges at another hospital in the Bronx for a while. And then our hospital decided I should not continue those privileges and was basically — basically, the hospital is no longer working as well with that other hospital and basically told me to drop my privileges with that other hospital.

**Q:** You voluntarily dropped your





privileges there?

**A:** Yes.

I was basically coverage for their emergency room. They don't do deliveries there.

**Q:** What's the name of that hospital?

**A:** Westchester Square, some modification of that name.

(Whereupon, Mr. Loucas exited the deposition.)

**Q:** Could you hand me the exhibits back? I, unfortunately, don't have copies.

You went to medical school at New York Medical College from 1982 to 1986?

**A:** Yes.

**Q:** And tell us about your medical training after medical school.

**A:** After medical school, I went up to Albany Medical Center and spent four years doing a general Ob-Gyn residency.

And then when I finished that, I applied for fellowship and came down to Cornell and spent two years in the maternal-fetal medicine fellowship there.





And then — you want me to just continue?

**Q:** Sure.

**A:** And then when the fellowship ended, I took over a contract to do all of the maternal-fetal medicine at Jersey City Medical Center, which is a hospital just across the Hudson River in Jersey City, and did all their maternal-fetal medicine and also worked two days a week at Cornell.

And that continued basically like that until 1997, when I moved up and took over — I was the chief of Ob-Gyn at Lincoln Hospital and at St. Barnabas Hospital at the same time.

And then — and then eventually St. Barnabas separated from Lincoln Hospital, so I stayed on as chief of Ob-Gyn at St. Barnabas Hospital, and that's where I am today.

**Q:** Doctor, I ask these in all depositions, but have your privileges ever been suspended or revoked?

**A:** No.

Q: You're licensed to practice only in New York and New Jersey?
A: Correct. I don't think I'm licensed right now to practice in New Jersey. I think I stopped paying.
Q: Stopped paying the dues?
A: Yeah.
Q: Have you ever been licensed anywhere else?
A: No.
Q: Has your license to practice medicine ever been suspended or placed under investigation?
A: No.
Q: Doctor, if there were — is there a textbook that you would state would be the best one for a person to learn about the general principals of obstetrics and gynecology?
A: No.
Q: I think — is there one used in your teaching?
A: To be honest, I would suggest





that there are so many books available it's hard to pin down. I mean, there are titles that are considered the, you know, most important, but I'm actually not so sure whether — I've been doing this for a while now — whether those titles are that much better than other titles in terms of the specifics.
Q: What are the preeminent titles?
A: Williams Obstetrics, Maternal-Fetal Medicine by Creasy.
But there's many others who are maybe just as good and could be better.
Q: Okay. As to the Williams textbook or the Creasy textbook, do you consider them reliable?
A: I think they all have their biases because they're written by people who automatically have biases.
So, I'm not sure I can answer the question.
Q: If I'm understanding you, no textbook, as opposed to peer-reviewed





articles, would you consider to be reliable.
A: Correct.
Q: Doctor, when did you first become involved in this case?
A: I received a phone call from — I think it was Mr. Becker, and I don't even know how many years ago that was, and he asked me to look at the case.
Q: Had you ever worked for Mr. Becker before?
A: No.
Q: Do you advertise your services as expert consultant?
A: No.
Q: Do you know how Mr. Becker found you?
A: No.
Q: Are you listed on any referral format through the internet or any organizations who connect lawyers that need expertise with experts?
A: No.
Q: And I take it that any billing arrangements for your time are directly





between you and Mr. Becker's office.
A: Yes.
Q: How much are you charging us for the deposition today?
A: I don't know.
Q: Okay. Do you have an hourly rate you're charging Mr. Becker?
A: I've not discussed it with him in any detail.
Q: How often do you review cases for lawyers?
A: Probably one a year or maybe less than that.
Q: How long have you been doing that?
A: Since I started my fellowship. My mentor couldn't handle some case, so he gave me the case. And then I did it once in a while from then.
Q: Do you have a breakdown of how often you're retained by the attorney for the patient as opposed to the attorney for the doctor or the hospital?

A: The vast majority are patient.
Q: Do you know why?
A: I have no idea why.
Q: Do you serve — other than in medical negligence cases, do you do medical legal consulting in any other area?
A: No.
Q: And do you know when the phone call was from Mr. Becker that first involved you in this case?
A: I do not, no.
Q: What have you reviewed in this case to reach your opinions?
A: In my report, it has a clear list of exactly what I have reviewed. And the only other thing that I've reviewed, which I just received recently, were a few of the expert reports.
Q: Just so the record is clear, we have the twelve items listed in your report, then there are additional items of certain expert reports.
Can you tell us which expert reports you have reviewed?





THE WITNESS: Do we have a book? There was a book you gave me last night. I think it was here, and he may have taken it away.
A: I think it's an up-to-date list of all of the reports of whatever has been done in terms of expert reports. I think I've done every one.
Q: Did you see a Dr. Bick's report?
A: Yes.
Q: Do you see Dr. Raymond Redline's report, the pathologist for the Plaintiff?
A: Yes.
Q: Have you seen doctor — let me see, Dr. Flam's report for the defense?
A: I'm not sure, what does he do?
Q: Obstetrics.
A: I don't think so, no. I may not have seen them all, because I'm pretty sure I did not see Dr. Flam.
We really should get the other book I got last night.
Q: Do you recall a Dr. Floyd's





report?
A: What does he do?
Q: OB.
A: I don't think I saw that either.
Q: Zabuy, Dr. Zabuy?
A: I saw Zabuy.
Q: You saw Zabuy. Dr. Baggans, hematology?
A: I'm not sure.
Q: Dr. Essig, I guess this is a nursing expert.
Dr. Essig?
A: I don't think so, no.
Q: So it would appear you haven't seen all the expert reports, but you have seen some.
A: I'm pretty sure I have not. Those two OBs I did not.
Q: Have you seen a report from Dr. Zacker out of the University of Cincinnati, Ronald Zacker?
A: What is his specialty?
Q: Pathology.
A: I'm not sure.





You want to send it over to me?
Q: We might do that, but my question right now is whether you've seen it before.
A: I don't...
Q: So other than some of the expert reports and the twelve items, that's entirely what you reviewed?
A: Uh-huh.
Q: Is that a booklet of the medical records before you?
A: Yes.
Q: Your copy of your report seems to be different than my copy of your report, as I look at it.
Could I see your copy for a minute? because it looks like the paper is different.
A: Actually, look at the date.
Q: You did one May 15, '04, and then the one I have is June 7, '04.
Are there differences between these two documents?
MR. AUCIELLO: Because I'll have that on the record, let's mark that as

number three, please.
(Whereupon, 5/15/05 Report was marked Exhibit 3 for identification.)
**Q:** Doctor, I don't remember if I asked it or not, but are there differences between these two reports?
**A:** I don't know.
**Q:** On a cursory review, I'm not finding any.
Is there a reason why you have — the report was issued on two different occasions, that you can recall?
**A:** I don't know.
**Q:** Other than the two dates on these two reports, did you issue any other reports or correspondence concerning this case?
**A:** No.
**Q:** Have you spoken to anyone other than Mr. Becker concerning this case or Mr. Loucas concerning this case?
**A:** No.
**Q:** Doctor, would you agree with me that a physician can't guarantee patient outcomes?





**A:** Yes, I would agree with that.
**Q:** And that patients can have bad outcomes from medical care even though they've received good medical care?
**A:** Yes.
**Q:** And I suspect even your patients have had bad outcomes.
**A:** Yes, they have.
**Q:** And you'd agree that the physicians in caring for patients have to rely on the facts and circumstances as they encounter them in the clinical setting.
**A:** Yes.
**Q:** You would agree that they don't have the benefit of hindsight, looking at the end backwards, when they're treating a patient.
**A:** That's correct.
**Q:** You would agree with me it's easier to evaluate a case when you're looking backwards in time as opposed to when the events are occurring?
**A:** Yes.
**Q:** You knew what happened to this





patient when you reviewed the case.
Correct?
**A:** It's hard to review a case without knowing what happened.
**Q:** You were sent the medical records, so you knew the outcome before you started.
**A:** Yes.
**Q:** Doctor, how do you define the standard of care?
**A:** It's what a reasonably prudent physician would do in similar circumstances.
**Q:** Is it necessarily perfect care?
**A:** I would call it safe care.
**Q:** Safe care.
Can doctors have differences in their approaches to illnesses and both be within the standard of care and — be above or within the standard of care?
**A:** Yes.
**Q:** Doctor, we touched on this a little bit, but I want to make sure.
At the time of trial, you're not going to come into court and identify any





particular textbook as being authoritative and reliable.
Is that correct?
You don't believe any of them are authoritative and reliable?
**A:** Correct.
**Q:** Are there any particular journal articles or pieces of the medical literature that you intend to offer them to the effect that they are reliable, set the standard of care, or that they are authoritative regarding any issue in this case?
**A:** No.
**Q:** If you do after this deposition locate some article that you believe is authoritative concerning any issue in the case, I would ask that you notify Mr. Becker so he can notify us.
**A:** Yes.
**Q:** Doctor, I represent Dr. Lucille Stine. She's mentioned in your report. Let me give you yours back. .
Does page seven contain all of your criticisms of Dr. Lucille Stine?

A: Yes.
Q: Doctor, what was the role of the house physician at Meridia Euclid Hospital back in the year 2000?
A: My understanding of the role of that person was to be in the hospital and be a practicing obstetrician-gynecologist and take care of patients, evaluate patients until their own private Ob-Gyn could come in and take over.
Q: Do you use house physicians here in New York?
A: I'm sure some hospitals do.
Q: Your hospitals, the two hospitals you mentioned you had privileges at?
A: At our hospital, they are definitely not house physicians.
At Cornell, maybe the residents in some way function as house physicians.
Q: But you don't have the position of a house physician who's not a student who is in attendance at the hospital to deal with emergencies and/or cover for the attendings until they arrive?





A: No, I'm actually going to change that.
Actually, in our hospital, if there's a private patient coming in, our Ob-Gyns probably do function something like a house physician, yes.
Q: So they stay at the hospital and handle any patient?
A: 24 hours a day.
Q: Have you ever worked in the role of a house physician?
A: Yes.
Q: When and where was that?
A: When I worked in St. Barnabas Hospital.
Q: And when was that?
A: Any time in the last eight years.
Q: So you go and you do a shift in the hospital and take all comers, whoever needs it?
A: I do it once in a while, yes.
Q: Dr. Stine's care began, I believe, around 23:30 or 23:35, where she did a history and physical.





A: Yes.
Q: Do you have criticism with the history and physical that she did?
A: No, I do not.
Q: I believe at 23:35 she issued a series of orders — and feel free to look at the medical records, if you'd like. I believe there's fifteen orders listed at 23:35.
A: Yes, I see them.
What was your question?
Q: First I wanted you to see them. Do you have any criticisms of those orders?
A: No.
Q: In your report, you indicate that — I believe it's numbered one — that Dr. Stine should have told Dr. Bailin that he was needed in the hospital immediately.
Is that accurately what the report says?
A: Yes.
Q: What did Dr. Stine tell Dr. Bailin?
A: I do not know at this moment the





details of the conversation, but I think it was not clearly stated to Dr. Bailin that the patient was severely ill and that he needed to come into the hospital immediately.
Q: What's the basis for your belief that it was not clearly stated?
A: Because her reply was that Dr. Bailin was coming in in the near future.
Q: And from that you deduced that he was not informed of the patient's condition?
A: Well, the fact that he did not arrive for about an hour would suggest that the communication was not clear.
Q: I just want to make sure I understand this.
Because the attending physician didn't arrive for an hour, it is your opinion that the house physician violated the standard of care in her communication to him.
Does that accurately reflect your opinion?
A: Yes.
Q: So, it is a violation of the standard of care for a house physician if the

Page 34

S. R. INGLIS

attending physician for whatever reason doesn't arrive in a timely fashion?
A: No.
I would suggest it's the standard of care if you have a severely ill patient that you know specifically when that physician is going to arrive.
Q: Tell me what information that Dr. Stine failed to relay to Dr. Bailin during their phone conversation.
A: That his patient was severely ill, that he needed to come in and evaluate the patient immediately.
Q: If Dr. Stine gave a complete history of the presentation of this patient and relayed to Dr. Bailin all the pertinent findings without saying she is severely ill, would that satisfy the standard of care?
A: Can you repeat the question?
Q: If Dr. Stine gave a complete history of the patient, what the labs were, what her presentation was, would that satisfy the standard of care?
A: No, I would suggest it wouldn't.

Page 35

S. R. INGLIS

I think she needs to fill in the nature of the illness and the severity to Dr. Bailin so that it states that he is coming in immediately.
Q: Do you know why Dr. Bailin didn't come in immediately?
A: I have no idea.
Q: So you don't know what reason he had in his mind to wait an hour?
A: Correct.
Q: You don't even know if his decision to wait an hour arose from something that Dr. Stine said or didn't say?
A: No.
Q: And as you admitted earlier, you don't know the substance of the conversation that occurred?
A: No, I believe in the testimony that Dr. Stine gave it was that she gave report to Dr. Bailin and it was — and from what I read, it was not clear that the patient was severely ill and in need of his immediate presence.
Q: Is there any clinical fact that

Page 36

S. R. INGLIS

you believe was withheld by Dr. Stine in her conversation with Dr. Bailin?
A: Yes.
Q: What?
A: It's that he's needed in the hospital immediately.
Q: That's a clinical fact about the patient's presentation, the condition of the patient?
A: Correct.
Q: What fact was omitted, just the statement that he needs to come in right now?
A: The piece that was missing was the statement to Dr. Bailin that you need to come to the hospital immediately.
Q: Now, tell me, how did this communication, this breach of the standard of care, cause the death of this patient?
A: I believe that Dr. Bailin did not understand the severity of the case and delayed for an hour, came in whenever he came in, and then that was part of the delay in the entire care of this patient.
Q: But I want to know how that

Page 37

S. R. INGLIS

delay, that — whatever it was from — he arrived before 1:15 because he delivered the baby at 1:15.
Correct?
A: Correct.
Q: Tell me how that hour of delay caused the death of this patient.
A: Because I believe that if he had come in ten minutes after that phone call, that they very well may have done the C-section right then.
Q: You believe had the C-section be done an hour earlier, this patient's life would have been saved?
A: I think there's a reasonable chance, yes.
Q: More likely than not?
A: Yes.
Q: Why?
A: Because by delaying the case, the patient will get sicker. There's only one way to slow down what's happened to this patient, and that's to deliver as soon as possible.
Q: What additional treatments or

therapy would have been provided to the patient had Dr. Bailin arrived in less time than he took?

**A:** I believe if Dr. Bailin had come in immediately, as he might have, there would have been a thought that maybe the patient should have gone to intensive care unit, maybe call maternal-fetal medicine, necrology, low dose dopamine, possible Swan-Ganz catheter, and blood pressure control.

**Q:** Are you contending low dose dopamine would have been appropriate at this time?

**A:** Possibly, yes.

**Q:** I have to go back and tell my client what you said were the violations of the standard of care and why you think these violations caused the death of this patient.

Is it your opinion that the standard of care mandated the administration of low dose dopamine to this patient during this hospitalization between 11:35 p.m. an 1:15 a.m.?

**A:** I believe the standard of care





mandated that someone, either Dr. Stine or Dr. Bailin, immediately start to move on whether this patient would be better off with all of those things.

**Q:** Doctor, my question is: Should low dose dopamine have been administered to this patient between 11:35 p.m. and 1:15 a.m. during this admission?

**A:** I don't know.

**Q:** Should a Swan-Ganz catheter be placed during that time period?

**A:** Possibly, yes.

**Q:** Why?

**A:** Because she had severe high blood pressure and her urine output was very low.

(Beeper sounds)

**THE WITNESS:** Can we stop for a minute?

**MR. AUCIELLO:** Sure. You need to respond to a page.

(Pause in proceedings)

**Q:** Doctor, what effect would low dose dopamine have had on this patient?

**A:** It possibly could have improved





her urine output.

**Q:** Is low dose dopamine generally indicated when a patient is hypotensive or hypertensive?

**A:** Generally hypotensive.

**Q:** Was Ms. McElfish hypotensive?

**A:** No.

**Q:** She was hypertensive?

**A:** Right.

**Q:** Would there have been a risk of giving low dose dopamine?

**A:** Yes.

**Q:** It's true it might have killed her?

**MR. BECKER:** At what point are you talking about, when she was hypertensive?

**Q:** When she was hypertensive, to give low dose dopamine.

**A:** I would — any medication could kill a patient, you name it.

There should have been a thought process as to what's going on. She needed help, and no one was called.





**Q:** Doctor, I want to know, you don't know what the thought process was, do you?

You only know what was written down.

**A:** I know that there was no note written in the chart that said we gave serious consideration to Swan-Ganz, anti-hypertensive medication, or whatever, management of the case. And if a specialist had been called, then those things would have been addressed.

I am not saying that automatically all of those things had to happen.

**Q:** What specialist would have addressed those two items, the low dose dopamine and the Swan-Ganz catheter?

**A:** Ideally, it would be the maternal-fetal medicine person, an anesthesiologist, or an intensive care or cardiologist. And ideally —

(Beeper sounds)

**THE WITNESS:** Can I answer that one too?

**MR. AUCIELLO:** Yes.

Page 42

S. R. INGLIS

(Pause in proceedings)

**Q:** Doctor, if I understand your testimony, you believe the standard of care required that Dr. Stine or Dr. Bailin consult a maternal-fetal medicine specialist.

**A:** No. I would say the standard of care is that there is a note addressing whether a — whether you're going to get a consult from the intensive care unit, maternal-fetal medicine, cardiology, nephrology, and whether you want to do a Swan-Ganz or address the blood pressure.

**Q:** You're saying the Swan-Ganz should have been done.

**A:** No.

**Q:** You're not?

**A:** I said a discussion.

**Q:** All right. You're saying the low dose dopamine should have been a discussion also, you're not necessarily saying it should have been administered?

**A:** The low dose dopamine at some

Page 43

S. R. INGLIS

point in the care of the patient might have been useful. I'm not saying specifically at any time.

**Q:** Is there a time when the standard of care mandated the administration of low dose dopamine to this patient?

**A:** Not that I know of, that it is mandated, no.

**Q:** Is there a point in time when the standard of care mandated that a Swan-Ganz catheter be placed?

**A:** Possibly, yes.

**Q:** When?

**A:** Possibly on admission, possibly during the Cesarean section, possibly in the recovery room, and possibly at the time she actually decompensated.

**Q:** Doctor, the possibly — either the standard of care required it or didn't or there's some variable factor that would call for it.

So, can you tell me at what point did the standard of care require this patient to have a Swan-Ganz catheter?

Page 44

S. R. INGLIS

**A:** When she decompensated, required.

**Q:** When was that?

**A:** That was at — I think it was 2:30.

**Q:** And at no other point was it required?

**A:** I would say it would be standard of care that there be a consideration of it, a discussion of it, with someone who is capable of doing that procedure.

**Q:** Okay.

**A:** Much earlier than 2:30.

**Q:** But it should have been placed by 2:30 or at 2:30?

**A:** Yes.

**Q:** And had that been done, would that have changed the outcome?

**A:** I would leave that to someone who is an intensivist to figure that out. I don't know.

**Q:** You don't know. Are you just going to testify about the standard of care as opposed to causation?

Page 45

S. R. INGLIS

**MR. BECKER:** No.

**MR. AUCIELLO:** Okay, then, I'll continue asking. Otherwise, I would have...

**Q:** Well, let me ask you this: Why don't you know whether placing a Swan-Ganz catheter at 2:30 in the morning would have changed the outcome?

**A:** Because, frankly, the only way to know is if you're standing there in front of the patient and you know every detail, and then you would have a higher chance of knowing whether they could have made a difference at that point in time. It's hard for me now to know that.

Possibly an intensivist that uses Swan-Ganz every day knows all the numbers, so they would have more knowledge of all the numbers of whether it could still have changed the outcome.

**Q:** Now I've got to go back to the low dose dopamine.

**Same question:** Was there a point in time — I think you already answered this,

Page 46

S. R. INGLIS

but just to make sure, there's not a point in time when the standard of care required the administration of low dose dopamine?

**A:** Correct.

**Q:** A nephrologist was consulted in this case.

Correct?

**A:** Correct.

**Q:** That was Dr. Lautman?

**A:** Yes.

**Q:** Are you critical of Dr. Lautman's care?

**A:** I think when Dr. Lautman saw the patient, there wasn't that much to be done.

**Q:** Why is that?

**A:** Because I think it was way after even 2:30.

**Q:** By wasn't much to be done, does that mean everything had been done already?

**A:** No, no, no.

There was not much therapy that Dr. Lautman could come up with. And, frankly, I'm not even sure Dr. Lautman was the proper consult.

Page 47

S. R. INGLIS

It would have been better off if they consulted an intensivist instead of the nephrologist.

**Q:** You said in your report that a nephrologist should have been considered at least.

Correct?

**A:** You could certainly consider it, and possibly a nephrologist could be of great benefit to this patient.

But in general, the best people would be the cardiologist or the intensivist.

**Q:** Doctor, your second criticism of Dr. Stine is numbered three.

Was there a two at some point?

**A:** I never noticed that. I don't know.

**Q:** Did the standard of care mandate that any other form of blood pressure control as noted in your report be implemented with this patient?

**A:** Yes.

I would say the standard of care is that when her systolic blood pressure got

Page 48

S. R. INGLIS

over 160, that she would be treated with Hydralazine or some other anti-hypertensive from the moment she walked in the door.

**Q:** Okay.

Hydralazine?

**A:** Hydralazine or a beta blocker.

It doesn't make a difference much what medication, but systolic over 160, diastolic over 110 needs treatment.

**Q:** When did that happen?

**A:** Basically, she entered with those numbers, and it was not treated.

**Q:** You indicate in your third criticism — it's numbered four — that Dr. Stine should have consulted with anesthesia for the planned Cesarean.

**A:** Yes.

**Q:** What difference would that have made?

**MR. BECKER:** Objection.

Asked and answered.

Go ahead, you can answer again, doctor.

**A:** By getting anesthesia involved at

Page 49

S. R. INGLIS

an earlier time, possibly they would have suggested other therapy for this patient.

**Q:** Like what?

**A:** Anti-hypertensives, consultation with other physicians.

**Q:** Specifically —

**A:** Swan-Ganz.

**Q:** Specifically, what would have happened to the patient that would have changed the result had Dr. Stine contacted anesthesia by 11:50?

**A:** Specifically, you would have another physician who knows a lot about all of those things I just said, and they may have suggested that all of those things happen.

**Q:** More likely than not, would anything have changed more likely than not?

**A:** I don't know. It's difficult to say.

**Q:** I guess the same question with the fourth criticism — numbered five — what would the difference have been had this patient been considered for admission into the ICU?

A: I think it's entirely likely that if the patient had been considered and in the intensive care and specialist contacted, that the therapy for the patient would have been substantially different.

Q: How would it have been different?

A: They may have recommended that the patient get a Swan-Ganz and that they read the blood pressure very carefully, and then the fluid management would be very carefully watched, the laboratory assessment would have been much more detailed.

Q: Who would have been attending to this patient had she been in the ICU?

A: The intensive care physician.

Q: Do you know who that is?

A: I do not know.

Q: I take it you're not critical of Dr. Lautman.

Is that true?

A: I don't have detail of his reputation. As I remember, his — his consultation was done relatively late, and I'm not sure that his therapy could have changed





the outcome.

Q: Do you have any criticisms of Dr. Stine after Dr. Bailin arrived no later than 1:15 a.m.?

A: I'm going to assume that the business relationship in that hospital is that Dr. Bailin takes over and is in charge of that patient and that all further decisions should be made by Dr. Bailin.

Assuming that is how the practice of that hospital functions, then theoretically one can argue that all decisions going forward would be coming from, really, Dr. Bailin, and it's up to him to determine whether Dr. Stine would even help, whether he wants to even talk to Dr. Stine.

Q: So based on that assumption — and I understand that's the assumption — you don't have any criticisms of Dr. Stine after Dr. Bailin's arrival, whenever it was?

A: Correct.

MR. AUCIELLO: Doctor, I don't think I have much more, but I'll let the other attorneys ask some questions, and





I'll follow up.

Somebody ready to go?

(Pause in proceedings)

EXAMINATION

BY MR. TREU:

Q: Doctor, my name is Kris Treu. I represent Dr. Bailin.

Can you hear me all right?

A: Yes, I can.

Q: Okay.

You have your report there, don't you?

A: Yes.

Q: Is the fact that this patient is a chronic hypertensive significant to your opinions in this case as it relates to the standard of care and Dr. Bailin?

A: Yes.

Q: And you note in your report at page five that the patient's blood pressure of 130 over 80 on March 2, 2000 indicates that the patient was a chronic hypertensive.

Do I read that correctly?

A: Yes.





Q: Can you tell me on what you base your opinion that 130 over 80 indicates that this patient is a chronic hypertensive?

A: Clearly, in the majority of the literature they're going to use the blood pressure of 140 over 90 as the criteria for chronic hypertension. I think in clinical medicine it's not that easy to absolutely say that you must hit those criteria to be called a chronic hypertensive and to have — it's better for the patient to be called chronic hypertensive, be given that diagnosis, and then given all of the care that we would give that patient who's a chronic hypertensive.

Q: The accepted literature does, in fact, define hypertension as a suggested blood pressure increase to levels of systolic of 140 or diastolic of 90.

Does it not?

A: Yes.

Q: And are you disagreeing with that literature?

A: I am disagreeing with the idea that to see a patient in your office who is 27

years old and to have a blood pressure of 130 over 80 and to call that normal.

**Q:** Does that mean you necessarily call it chronic hypertension?

**A:** I think in a lot of clinical medicine the standard is to just give that sort of patient the diagnosis of hypertension and all of the care.

**Q:** Is it your testimony in this case that the standard of care requires a physician to treat a patient with a blood pressure of 130 over 80 as a chronic hypertensive?

**A:** I would say the standard of care is to — is to carefully monitor that patient, and I would say that a lot of people will give that patient the diagnosis of chronic hypertension to make sure that that monitoring occurs.

**Q:** That being said, you would agree with me that the standard — the understanding in your specialty is that chronic hypertensive is not — doesn't reach that level until they are 140 over 90.

True?





**A:** We agree the strict criteria is 140 over 90. There's no doubt about that.

**Q:** All right. And that is generally understood to be a patient who reaches that blood pressure within the first twenty weeks of pregnancy.

Correct?

**A:** Correct.

**Q:** Did Ms. McElfish meet that criteria in this pregnancy?

**A:** She did not meet that blood pressure criteria that we know of, no.

**Q:** Okay. The third criticism that you list in your report on page five is that the practitioners in this case have the incorrect due date for this patient.

**A:** Yes.

**Q:** That's based on the prenatal flow records.

Is that correct?

**A:** Yes.

**Q:** Would you agree with me that





during Ms. McElfish's admission to Meridia Euclid Hospital, her outpatient evaluation summary indicates her EDD by sonogram is September 18?

**A:** I believe it is the case, yes.

**Q:** And that's also documented in the records during her admission on September 16.

Correct?

**A:** I don't have that in front of me, but I'll leave it to you this way: I believe there was a lot of confusion as to what her gestational age was, and out of — that confusion is very significant when you're pregnant and you have a very complicated pregnancy. The failure to clearly write on the piece of paper what the proper due date is and use it is concerning.

**Q:** Other than that, are you aware of any testimony indicating that there was mass confusion about this patient's delivery date, estimated delivery date?

**A:** In terms of testimony, I don't know of any vast confusion, but I clearly saw through the record multiple places where





different people were saying different gestational ages. I think it's even on the admission — the very last admission, it even says question mark there versus that.

**Q:** With respect to the management of chronic hypertension set forth in your fourth criticism on page five, what baseline work-ups does the literature recommend?

**A:** It usually recommends if you're a chronic hypertensive 24-hour urine, complete blood count, liver functions, maybe an antinuclear antibody if you have hypertension, maybe uric acid, and maybe other tests depending on the specifics of that patient.

**Q:** You're aware, of course, that the patient was admitted to the hospital on August 21 for work-up.

Correct?

**A:** Correct.

**Q:** And during that inpatient admission, her urine protein was negative.

Correct?

**A:** As I remember, yes, that is.

**Q:** Her creatinine was within normal

limits.
True?
**A:** I'm not sure of that. Hang on a minute.
You said 8/21?
**Q:** Correct.
**A:** What was the creatinine level, do you know?
I see it, it was zero point seven and the BUN was eleven, and neither of these are normal.
Creatinine is zero point seven and BUN is 11.
**Q:** Is that within normal limits?
**A:** I would say for pregnancy, no.
**Q:** What makes it different for pregnancy?
**A:** In pregnancy, the creatinine clearance goes up substantially, so you expect the creatinine to come down. So, you have a zero point seven, which is upper limit of normal for pregnancy, and then the BUN of eleven is high. So if you did a 24-hour urine, you may find there's already renal





insufficiency.
**Q:** How was her uric acid level?
**A:** I don't know.
**Q:** Why not?
**A:** I don't see it in front of me.
**Q:** Were her PIH labs normal?
**A:** Well, it depends on your definition of normal.
A BUN of eleven and a creatinine of zero point seven are questionable to begin with.
**Q:** What about liver enzymes?
**A:** The liver enzymes were normal. I do remember that.
**Q:** And what were her blood pressures during that confinement?
**A:** I see two blood pressures; I see 123 over 56, and then 144 over 86 while she's resting in bed.
**Q:** Are those normal?
**A:** No.
**Q:** What's abnormal?
**A:** Clearly, anything over 140 systolic is not normal, and the 86 is almost





90 so that's almost abnormal too.
By any definition, those are not normal.
**Q:** So the systolic was four points over the normal level?
**A:** Correct.
And that's enough to make you mild preeclampsia.
**Q:** But, again, there's no indication of any abnormality in the kidney function.
True?
**A:** No.
There's an indication. The BUN was eleven and the creatinine zero point seven, which is the upper limit of normal for pregnancy.
**Q:** But it's still normal?
**A:** The BUN is not normal. The creatinine of zero point seven is the upper limit of normal for pregnancy.
**Q:** Ms. McElfish was worked up again on December 5, 2000.
Correct?
**A:** Yes.





**Q:** How was her creatinine at that time?
**A:** As I remember, it was better. I think it might have been zero point five.
**Q:** Her uric acid?
**A:** As I remember, it was four point something.
**Q:** Normal?
**A:** Yes.
**Q:** AST was fifteen.
Correct?
**A:** Correct.
**Q:** Anything abnormal about that?
**A:** No.
**Q:** Her ALT was 24.
Correct?
**A:** As I remember, yes.
**Q:** That's normal as well?
**A:** Yes.
**Q:** Her blood pressure on that date at two in the afternoon, 1400 hours, was 124 over 69?
**A:** I don't have it in front of me. As I remember, the blood pressure

was better when she got in the hospital and was resting.

**Q:** And the repeat blood pressure done shortly after that was 130 over 70. Correct?

**A:** Yes.

**Q:** And during that confinement, her blood pressures continued to remain well within the normal range. True?

**A:** Yes, they were at that moment normal, yes.

**Q:** With no evidence of any kidney malfunction?

**A:** Well, there was certainly some evidence when she had a one plus protein when she was in her outpatient visit the same day.

**Q:** Talking about in the hospital.

**A:** Oh, in the hospital. If the urines were negative, then at least those dip sticks were normal.

**Q:** Any evidence of any other end organ involvement during that admission?

**A:** Well, if she was complaining of





headache, that would be concerning.

**Q:** Was she?

**A:** I don't know whether she'd stopped complaining, but earlier that day she did have a headache, yes.

**Q:** But there's no documentation of that in hospital?

**A:** Not that I have right in front of me. I don't know.

**Q:** So, can we say that during the time of that confinement, based on all of the studies and tests that were done during that confinement, there's no evidence that she was suffering from preeclampsia or any end organ involvement from preeclampsia?

**A:** I'm not sure you can say that.

**Q:** Why not?

**A:** Because to really determine whether she had preeclampsia she needed more work.

**Q:** I'm asking you based on the studies that were done that day.

**A:** You cannot come to that conclusion.





**Q:** Is there anything based on the studies that were done that day that would lead you to the conclusion that she was preeclamptic?

**A:** Yes, a blood pressure of 160 over 86, one plus protein, fatigue, headache, numbness in the hands, all of that does make me concerned that she does have preeclampsia.

**Q:** Which is why she was taken in the hospital and these studies were done. True?

**A:** Yes.

**Q:** And none of those studies nor any of the examinations done in the hospital that day indicated any signs or symptoms of preeclampsia. Correct?

**A:** They did not do the tests to make sure the patient did not have preeclampsia. None of the tests that they did do indicated any signs or symptoms of preeclampsia, correct. The tests they did earlier that day did show there were signs and symptoms of





preeclampsia, yes.

**Q:** Doctor, could you answer the question I'm asking you, please? My question was quite simple; that is, the tests and the studies and observations that were done during the confinement on September 5, 2000 did not disclose any evidence, signs, or symptoms of preeclampsia. Isn't that true?

**MR. BECKER:** Objection. Asked and answered.

**MR. TREU:** No, it wasn't.

**A:** No, they did not.

**Q:** With respect to the criticisms contained in paragraph five of your report, it begins at the top of page 6, do you believe the anti-hypertensive therapy during Ms. McElfish's course was indicated?

**A:** Yes.

**Q:** What factors warranted the administration of anti-hypertensive medication during this patient's prenatal period?

**A:** Any time her systolic blood

pressure went over 150 or her diastolic went over 105, it would be standard to start anti-hypertensive therapy.

**Q:** For how long?

**A:** You would basically keep it going to — until you had a therapeutic effect to keep the blood pressure down around a 140 over 90 range. As long as you had that, then you've got the proper therapy.

**Q:** Was there any evidence from the confinements in August and September that this patient needed hypertensive medication, anti-hypertensive medication?

**A:** Yes.

**Q:** And what was that?

**A:** Her hypertension.

**Q:** During the time she was confined?

**A:** Yes, in one of those admissions she had a 140 over 88.

**Q:** Why don't you tell me, doctor, based on your review of the records, when this patient first should have been placed on anti-hypertensive medication.

**A:** I would suggest that it would





start the first time her systolic blood pressure was over 150 and the diastolic was over 105, and that would be — 8/21 is the first time I see a blood pressure of that degree of hypertension.

At that time, then, if that is prolonged, continuing to have that degree of hypertension, then she would be started on an anti-hypertensive medication.

**Q:** We know it wasn't prolonged on that date, don't we, on August 21?

**A:** We don't know because they did not check blood pressures other than, you know, about three times total.

**Q:** Well, we know that when she was put in the hospital that day that neither of her blood pressures were abnormal.

True?

**A:** We do know for that interval of time, that, yes, that they were not elevated or not elevated to the level I just said to require —

**Q:** So, would you have started her on anti-hypertensive medication in the office





before you admitted her for these tests?

**A:** No, I would not have started anti-hypertensives the first time I started that blood pressure.

**Q:** So, would you have started them, then, based on what you found during that confinement on August 21?

Would that justify starting that patient on anti-hypertensives?

**A:** What I would have done is had the patient admitted and watched the blood pressure carefully, and then if she continued to have blood pressures of 150 or higher or diastolic of 105, I would have started anti-hypertensive medication.

But as your patient specifically said, for those blood pressures when she was observed in the hospital, then I guess the answer would be no since they didn't admit her.

**Q:** So then going forward, when would you have prescribed anti-hypertensives for this patient?

**A:** The next day when her blood





pressure was 140 over 100, the next day.

**Q:** And then how long would you have maintained her on those medications?

**A:** All the way until delivery most likely, considering her blood pressure tends to be very high all the way.

**Q:** Did it?

**A:** The only one that I see is still hypertensive but is a little better, the only one I see there is on 9/8 she is 134 over 84, then they checked again 154 over 84, so she went right back up again.

**Q:** What about during the admission of September 5?

**A:** I think we already went through that.

**Q:** There were not.

Correct?

**A:** The blood pressure was better for that little interval of time.

**Q:** And what about on September 14 when she had her NST done in the hospital, what was her blood pressure on that date?

**A:** I don't have it.

S. R. INGLIS

Could you remind me?
**Q:** 130 over 70.
**A:** So that's abnormal.
**Q:** Normal?
**A:** No, it's not.
**Q:** It's not?
**A:** 130 over 70?
**Q:** Yeah.
**A:** It is not a normal blood pressure in pregnancy by any stretch.
**Q:** Is it hypertensive?
**A:** Yes.
**Q:** Not according to any definition in the literature.
Correct?
**A:** 130 — did you say 70 or 80?
**Q:** 70.
**A:** 70 is not a normal blood pressure when you're pregnant and you're 28 years old.
**Q:** You're familiar with the — are you a member of ACOG?
**A:** Yes.
**Q:** Are you familiar with their publications?



S. R. INGLIS

**A:** Yes.
**Q:** Are you familiar with the technical bulletin dealing with hypertension in pregnancy?
**A:** Yes.
**Q:** Is that a reliable publication?
**A:** It's a good publication.
**Q:** Is it something that most practitioners rely on to provide them with reliable and reasonable information in their practice?
**A:** Some will rely on it, yes.
**Q:** Don't most?
**A:** Maybe most.
**Q:** But not you?
**A:** I am interested in taking care of the patient. A blood pressure of 130 over 80 in a 28 year old is not normal.
**Q:** So, just so the record is clear it was 130 over 70, but I don't think it —
**A:** I'm sorry?
**Q:** — matters to you.
With respect to the criticism contained in paragraph six of your report,



S. R. INGLIS

what literature supports home blood pressure monitoring is issued when blood pressure control is difficult?
(Beeper sounds)
**THE WITNESS:** Can you hang on a second?
**MR. TREU:** Sure.
**MS. DiSALVIO:** Why don't you take a few minutes, if you don't mind?
(Recess taken)
(Record read)
**MR. BECKER:** I think he wants to know if you can cite any literature to support number six off the top of your head.
**Q:** Doctor, I can't tell if you're pondering a question or waiting for me to ask another question.
**A:** I am pondering.
**THE WITNESS:** Would you mind repeating the question?
(Record read)
**A:** In paragraph six, what I am — I don't have any specific literature for you on



S. R. INGLIS

that. I'm simply stating that using home blood pressure monitoring may help you to determine better what her blood pressure status is, and it could be used instead of admitting the patient to the hospital or whatever. It was just an option that could have been considered.
I don't think there was a standard.
**Q:** Thank you. I jumped to a conclusion in that question.
Is there anything in numbered paragraph six on page six where you are indicating that there was some breach of accepted standards of care on behalf of Dr. Bailin, or are these just general statements that you're making?
**A:** Correct, I think these are general statements and I do not think they directly apply.
**Q:** Okay. Thank you. We'll move on to paragraph seven, then.
Is it your opinion in this case that this child should have been delivered

prior to September 17, 2000?
A: Yes.
Q: Do you have an opinion as to when this child should have been delivered?
A: I do not have a specific, no.
Q: Would you agree with the statement that delivery is always an appropriate option in the term patient with hypertension; however, in a patient with an unfavorable cervix who exhibits only mild blood pressure elevations, minimal proteinuria, and no evidence of either maternal end organ development or fetal compromise, delivery may be delayed in an effort to obtain a more favorable cervix prior to induction?
A: Can you state it one more time for me?
Q: Sure.
Delivery is always an appropriate option in the term patient with hypertension; however, in a patient with an unfavorable cervix who exhibits only mild blood pressure elevations, minimal proteinuria, and no





evidence of either maternal end organ development or fetal compromise, delivery may be delayed in an effort to obtain a more favorable cervix prior to induction.
A: Yes.
Q: Is it your opinion that Ms. McElfish did not meet that definition?
A: Yes.
Q: In what way?
A: There was not enough monitoring to determine whether she was — would fit that criteria.
Q: Again, to meet the accepted standard of care, what additional monitoring has to be done in this case?
A: She needed to be worked up for preeclampsia and she needed blood pressure monitoring.
Q: And what would you look for in the blood pressure monitoring to indicate that earlier delivery was necessary?
A: If the blood pressure was high despite bed rest and she had any evidence of preeclampsia, then she wouldn't fit the





criteria and she would need to be delivered.
Q: Can we agree that every time that she was put on bed rest in the hospital or was laying on her back having an NST done and her blood pressures were taken, they were within normal range according to the ACOG criteria?
A: No.
Q: When was that not the case?
A: The time when she got a 140 over 88 or 144 over 86. I think it was 8/21.
But if it will make you feel better, I do agree she seems to have done a little better when lying on her back in the hospital.
Q: Aside from that one slightly abnormal blood pressure according to the ACOG criteria, otherwise whenever she was laying down she had normal blood pressures.
Isn't that true?
A: I'm not sure I would call them normal.
Q: According to the ACOG criteria, 140 over 90.
A: Okay, if you want to use





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

Q: I'm saying based on what was checked.

A: Specifically, if you're talking about when the patient was admitted to the hospital, those tests are not administered on outpatient basis. I think I already said no, there was nothing that they did that clearly showed us that she had preeclampsia.

Q: Now, I'm looking at paragraph nine, page six. You say from August 21 on, the patient needed weekly visits, nonstress tests, and frequent blood pressure checks preferably at home.

Were her visits after August 21, in fact, weekly visits?

A: I think they may have been weekly.

Q: Did she have routine nonstress tests done from that point forward?

A: I believe she did.

Q: And those nonstress tests were always within normal limits?

A: I believe they were, yes.

Q: You indicate in criticism number





ten on page seven of your report that maternal-fetal medicine consultation was required.

Is that your opinion to a degree of probability to meet the accepted standard of care?

A: I would suggest that I am really stating number ten there as a general rule unless you feel — the physician feels completely comfortable with the management of the case.

Q: Okay. Now you've got — again, following that paragraph ten on page seven, you've had a heading entitled intrapartum substandard care. I do not see Dr. Bailin's name referenced in that particular subheading.

Can I be comfortable in the fact that you are not going to opine on the fact that Dr. Bailin failed to meet the standard of care for the intrapartum period for this patient?

A: Well, no, I don't think you can come to that conclusion.





Q: Okay. Again, I don't see his name mentioned there.

Do you have criticisms of him during this time period?

A: Well, assuming that Dr. Bailin was the one who took over responsibility for the patient as soon as he arrived, then any of my remarks of anything that was — could have been different would apply to him.

Q: Well, let me see if I understand.

Dr. Bailin, as you know, was called a few minutes before midnight.

Correct?

A: I'm not sure of the time. I actually thought it was earlier.

MR. TREU: Somebody say something at that end?

THE WITNESS: I don't know what the question is.

Q: The question is: Is it not your understanding that Dr. Bailin was called at a few minutes before midnight?





A: Yes, I believe that is correct.

Q: And as you discussed earlier in your deposition, he arrived approximately an hour later?

A: Yes.

Q: Around one in the morning?

A: I believe something like that, yes.

Q: And recognizing the situation, you'd agree with me that the only treatment for a patient who is in the throes of HELLP syndrome is rapid delivery of the child.

Is that true?

A: Absolutely, yes.

Q: And Dr. Bailin did that in this case.

Can we agree on that?

A: Yes.

Q: The child was delivered by 1:18 in the morning?

A: Yes.

Q: Are we now beyond the intrapartum portion of the case once the child is delivered?

A: Well, technically, yes, they would begin postpartum at that moment.

As to whether there is — are you saying there's no issue with how Dr. Bailin performed prior to that moment?

Q: All I'm trying to do is make sure I understand the parameters, number one.

Then I was going to ask you the question: What was it between 1 o'clock when Dr. Bailin arrived and 1:18 when he delivered this child that he should have done differently if you believe he should have?

A: I would say there's nothing that I would say that he should have done differently. My only question is that when you go to the care that occurred for when she got admitted to when he arrived, I don't know where the responsibility lies between Dr. Stine, Dr. Bailin, but Dr. Bailin may have not performed well. I don't know.

Q: As we sit here today, you can't say during that time period between the time he was called and the time that he arrived, you don't know whether there was something





more he should have done during that time period or not?

A: Correct. My instinct is to — the physician that is there seeing the patient is primarily responsible, and then they need to take over. And then — and I don't know if that's right, but that's how I look at it.

Q: Okay. You're aware that Dr. Stine is actually a maternal-fetal medicine specialist?

A: I am, yes.

Q: And you're just not clear in your mind as to what information was relayed to Dr. Bailin when he was initially called.

Is that true?

A: Correct.

Q: Or the extent to which he was — strike that question. So, let's go, then, to the postpartum care.

Are you aware of whether there was, in fact, an intensivist available at this institution for consultation?

A: I'm not aware.





Q: What is your understanding as to when Dr. Lautman was first contacted by Dr. Bailin on consult?

A: My understanding is that it was probably even after 2:30.

Q: I think if you look at records, that will indicate that he was called before 2:30, at approximately 2:15.

A: Okay.

Q: And he was consulted on management of the patient's — at that point, I believe hypotension after she had received the — what was it?

A: I think Apresoline.

Q: Right.

A: That's Hydralazine.

Q: First of all, was it in your mind appropriate to give her that Hydralazine at that time?

A: Would you mind if we go back and look?

I actually don't remember that well.

Q: Please do.





A: Do you have any idea where the records would be of that?

MR. AUCIELLO: My summary indicates it's in the nursing notes.

I don't have my records with me.

A: I think I see Apresoline at 2:04 and another one at 2:15, five milligrams.

Q: The question is: Was that appropriate therapy at that time?

A: I'm just checking the blood pressures just before that.

I don't know the answer to that one.

Q: Okay. Was it appropriate for Dr. Bailin to consult with Dr. Lautman?

A: Yes, it was appropriate for him to consult anybody he wanted to help.

Q: And just so I understand, what are your criticisms of Dr. Bailin's care of this patient postoperatively?

A: I think they're in the report. I believe that after she was delivered, she was very, very sick. And all of the things that I

think could have happened before the delivery could have happened right after the delivery.

**Q:** We know he consulted with a nephrologist, and we know he consulted with a hematologist postoperatively.

**A:** Okay.

**Q:** And we know that blood products were given and fluids were given.

**A:** Yes.

**Q:** So I guess my question is: What more should Dr. Bailin have done in your opinion to meet the accepted standard of care postpartum?

**A:** She needed to be monitored in a critical care sort of setting, either in the recovery room there or up in an ICU, and she needed consultation from those other specialists, such as an intensivist or cardiologist or maternal-fetal medicine, and she needed all of those things basically in the recovery room when she left the operating room.

Possibly she should have gone straight from the operating room to the ICU.





**Q:** Do you have an opinion as to at what point in this patient's course it was too late to save her?

**A:** It's not easy to say. I do think — I guess it would be sometime after the 2:30 episode, it would have been. But I would leave that to an intensive care specialist or something like that.

**Q:** Okay. Doctor, when you reviewed the records in this case, did you make any markings or highlightings or anything of that nature on the documents?

**A:** Not really much, no, I don't see any.

**Q:** Did you make any notations in the margins of any of the depositions or anything that you read?

**A:** No.

**Q:** Are you one of those people who puts Post-its on things when they go through to mark things that they want to go back and look at?

**A:** Yeah, I probably did, yes.





**Q:** Would you have made notations as well or just stuck a Post-it in the page?

**A:** Probably a Post-it.

**Q:** And why would you do that?

**A:** Just significant events where I can tell what somebody was thinking, what they were doing with the care of the patient.

During a deposition, if someone figures out at this moment the patient was very sick, that's — at that moment you can at least know what's going on in their head.

**Q:** Did you bring all those documents with you to the deposition today?

**A:** I did not. Those depositions, I can't even find right now. They may be somewhere, but they're not easily found.

**Q:** What did you bring to the deposition today?

**A:** Just the prenatal record and my report, I think is it.

And I did bring back, though — there were a few reports that I reviewed just recently, and I brought those back, and George





Loucas took those with him.

**Q:** And you said the prenatal records.

Did you review the actual labor and delivery records?

**A:** Yes.

**Q:** Do you have those?

**A:** Yes, I believe this is a complete — yes.

**Q:** You've made reference to a booklet of reports.

**A:** Yeah, it was a booklet of expert reports, I think was the proper term.

**Q:** Is that something that you had reviewed prior to yesterday?

**A:** No.

**Q:** So that was something — a book that was shown to you yesterday when you met with counsel?

**A:** Yes.

**Q:** Did that include both plaintiff and defense expert reports?

**A:** Yes, both.

**Q:** Aside from those documents, have

Page 90

S. R. INGLIS

you reviewed anything additional to the items set forth in your report letter that was provided to us dated June 7, 2004?

A: There's one more thing, I think. I reviewed the deposition of Dr. Stockwell. That and those reports that were in that folder.

And that was it, in addition to this stuff you see on my report. That was it.

Q: So you have read Dr. Stockwell's report — I mean deposition.

A: Deposition, correct.

MR. TREU: Doctor I'm going to take a break for now, see if anyone else has any questions for you.

EXAMINATION
BY MS. DiSALVIO:

Q: Dr. Inglis — am I pronouncing that all right?

A: Inglis, but I use Inglis.

Q: My name is Marilena, so I get a lot of mispronunciations of my name.

A: My wife can't figure out which my

Page 91

S. R. INGLIS

name is, actually.

Q: You better tell her. Who's in the room with you?

A: A bunch of lawyers and a court reporter.

Q: Who are the bunch of lawyers?

A: Michael Becker, and I'm forgetting his name, the lawyer for Dr. Stine.

Q: I thought I heard you mention Dr. Loucas.

A: He was here. Maybe he left even before the whole deposition got started.

Q: When did you meet with him?

A: I met with him yesterday.

Q: How long did you and he spend together?

A: About an hour, maybe an hour and a half.

Q: And then today you met with Mr. Becker?

A: With Mr. Becker and Mr. Loucas.

Q: Again?

A: Again.

Q: How much time did you spend

Page 92

S. R. INGLIS

today?

A: 30 minutes, 35 minutes.

Q: Have you reviewed any other cases for Mr. Loucas prior to this case?

A: No.

Q: For Cathy Loucas or Penny Loucas?

A: No.

Q: Any other cases for plaintiffs' lawyers in Northeastern Ohio?

A: No.

Q: I see that you wrote a report, and it looks to me sort of like you did a nice comprehensive review of the materials that were provided to you prior to reducing your opinions to writing.

Yes?

A: I'm sorry, say that again?

Q: You wrote a report. At least the one I have is dated June 7, '04.

Do you have that with you?

A: Yes.

Q: I think it's been marked as an exhibit, and it's eight pages of your opinions.

Page 93

S. R. INGLIS

Yes?

A: Yes.

Q: And in good fashion as an expert, it appears to me that you undertook a nice thorough review of all of the materials provided to you and then set forth all of the pertinent opinions that you hold in this case.

True?

A: I tried my best.

Q: And you stand behind your report. Yes?

A: Yes.

Q: Anything that you wish to add to, delete from, modify, relative to your report?

A: Not at this moment.

Q: Let me tell you what we're going to do.

You've been asked a lot of questions today. I'm going to ask you some questions now on behalf of the nurse midwife.

At the conclusion of my questions or the conclusion of the questions that may be asked of you by the hospital attorney, if you have any changes, modifications, deletions to

make to your report or opinions, I ask that you make them today; otherwise, we'll rely on them for trial.

All right?

A: If that's okay with Mr. Becker, yes, I guess.

Q: St. Barnabas Ob-Gyn, P.C., what's that?

A: It's a corporation that I run that employs ten Ob-Gyns and four midwives and PAs some of the time to do all of the obstetrics and gynecology up at the hospital.

Q: Is it a for-profit organization?

A: I think it could theoretically be a for-profit, but it is definitely part of the hospital and the hospital is nonprofit.

Q: Help me out on that one. What do you mean theoretically?

A: Are you familiar with the term captive P.C.?

Q: Yes.

A: That's what it is.

Q: Who are the ten OBs you employ?

A: They are all general Ob-Gyns, and





then the midwives are all certified nurse midwives.

Q: Do you have an affiliation with Dr. Chirvinack?

A: Sure do.

Q: Tell me about that.

A: I'm still part of the program at Cornell. I'm an associate professor. I participate in — I refer cases back and forth, I go to meetings, discuss. We're good friends. He was my mentor.

Q: That's great. So you certainly respect what he's got to say or what he's written. Right?

A: Yes.

Q: Very good. Tell me, sir, are you going to be providing any criticisms of the nurse midwives Beregovskaya and Ruzga?

A: The way I look at this case is that the responsibility lies with the Ob-Gyn or Ob-Gyns plural who are responsible for those midwives.





So, I — I mean, I think there were some things — for example, I don't think there was a physical exam documented on the prenatal care, you know, form or anything like that, but I think those are relatively minor in the whole scheme of things.

Q: And, so, you would agree with me that those nurse midwives acted appropriately in referring this patient for obstetric consultation on August 21 and on September 5 and on September 8, and to that end you will not criticize them. Yes?

A: With one exception. The only thing I'm thinking is whether they bounced back almost ever y one of those prenatal visits. They may have. I'm wondering whether they actually — when they saw her 8/21, they certainly bounced it to them. Whether they saw it again, bounced it again every single time — as much as possible, they have to let the physician be aware of what they're doing. If the physician thinks it's all right, I don't expect the





midwife to overrule it and admit the patient for themselves because they're so worried about the patient.

Did I answer the question?

Q: Yes, it does. I think we'll explore a little further.

With respect to this lawsuit, sir, did you review what the American College of Nurse Midwives says about involving and collaborating with a physician?

A: I did not read that.

Q: Did you read the Ohio Nurse Practice Act relative to the role and responsibility of the nurse midwives in connection with the collaborating obstetrician?

A: I did not read that document either.

Q: Certainly you know from your practice, sir, that when you were consulted or collaborated with by a nurse midwife, you step in and you do the evaluation as requested of you. Yes?

A: Yes, correct.
Q: And then once you are consulted and you are collaborating, you undertake in that role of supervising physician as has been requested of you.
True?
A: Yes.
Q: So from August 21 forward, you would agree that nurse midwife Beregovskaya did the appropriate thing in associating with and collaborating with Dr. Bailin, and from that point forward he became responsible for the patient's management.
True?
A: Do you by any chance know whether they did refer every single time the midwife to them when they're in that clinic?
Q: Let me ask you what you've seen and the testimony you've reviewed and your understanding, sir, about the practicalities as relates to the relationship between the nurse midwife and collaborating Ob-Gyn from August 21 forward.
Once the call for collaboration





and consultation was made, Dr. Bailin and/or Dr. Bailin's colleagues became responsible for this patient's primary care and treatment relative to her obstetrical care.
True?
A: I agree with you.
Let me just say one thing, though. The only thing I'm worrying about is whether possibly the patient called the office or something and they didn't refer it back. But the general concept of what you're saying I agree with; on 8/21, clearly the case was not a midwife case anymore, and it became the responsibility of them.
My only concern is whether there was any other clear medical issues that they did not forward to the physician. It may not have happened. It's basically —
Q: There's certainly none that you can think of as we sit here today?
A: Yes, correct.
Q: And you don't know of any phone calls that were made by the patient to the office.





True?
A: Correct.
Q: And, in fact, you know that the patient was asked to call in to see Dr. Bailin once on a repeat visit and failed to do so.
Right?
A: I don't know that, but... I don't remember that specifically, but if it happened, I'm...
Q: Fair enough. Have you sent Mr. Becker or Mr. Loucas a bill for your services to date?
A: I believe I did.
MS. DiSALVIO: Terrific. I'd like a copy of it, please, Mr. Becker. I'd make a formal request for that, please.
Q: Dr. Inglis, in connection with your opinions in this case, did you undertake any sort of literature review?
A: No.
Q: Did you take a look at any of the ACOG technical bulletins or practice bulletins?





A: I may have previously at the time when I did this report, but I haven't in the last six months or eight months looked at any of those technical bulletins, no.
Q: You're a member of ACOG. Yes?
A: Yes.
Q: I think you're a fellow. Yes?
A: Yes.
Q: That's more than a member. Yes?
A: No. I think if you're board certified, you get to be a quote/unquote fellow.
Q: All right. And you receive the publications of ACOG?
A: Yes.
Q: You read them and believe them to be reliable.
Yes?
A: Regarding the prior deposition I

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

**Q:** What deposition are you talking about?

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

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

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

Do you?

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





below the standard of care, no.

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

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

**MR. BECKER:** The answer would be no?

**THE WITNESS:** No.

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

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





more than the minimal care.

**MS. DiSALVIO:** Could you read back my question?

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

(Record read)

**A:** First of all —

**MR. BECKER:** Just answer the question directly.

**A:** No.

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

**A:** No.

**Q:** I want to go now to the prenatal record.

And before we do that, did I hear you correctly that you reviewed Dr. Stockwell's testimony?

**A:** Yes.

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

**A:** Yes.





**Q:** Where is that book now?

**A:** I think Mr. Loucas has it.

**Q:** Is he with you there?

**A:** No.

He's headed back to Ohio at the moment, I believe.

**Q:** What else was in that book?

**A:** It was simply expert reports.

**Q:** Are you acquainted with any other experts in this case?

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

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

True?

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

**Q:** And you consider him to be an authority on hypertensive disorders in pregnancy.

True?

**A:** I would say that he has his

opinion and some people believe and follow exactly what he does, and some people do much more; they do additional work to keep their patients healthy.

**Q:** His opinions are actually in a big giant book called Hypertensive Disorders in Pregnancy.

Correct?

**A:** Correct.

**Q:** Do you own that book?

**A:** I do not.

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

**MR. BECKER:** I'm going to object to questions based on what Dr. Stockwell had to say.

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

**MS. DiSALVIO:** You can object, Mike, but he read Dr. Stockwell's





deposition, so I'm going to inquire of whether he agrees.

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

**A:** No.

I believe she had another risk factor.

**Q:** Which is?

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

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

Would you disagree with that?

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

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

There's no history of





hypertension prior to pregnancy for this patient.

Is there?

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

**Q:** You don't have any evidence that she does that I don't have.

Do you, sir?

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

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

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

You disagree with that?

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





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

**MS. DiSALVIO:** Can you please read back my last question and see if you can give it an answer?

(Record read)

**Q:** Do you disagree with Dr. Stockwell?

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

We agree.

**Q:** All right.

You agree with Dr. Stockwell that the management of this patient through and up until August 21 was entirely appropriate?

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

**Q:** You would agree that from the

Page 110

S. R. INGLIS

hospitalization of August 21, you would agree with Dr. Stockwell that the only thing that is a little bit worrisome is the blood pressure of 144 over 86.

Agreed?

MR. BECKER: I'm going to again object to you quoting Dr. Stockwell to this doctor.

I think, Marilena, you have a right to ask him what his opinions are and the basis of his opinions, but I think it's inappropriate to ask him if he agrees with sworn testimony from another doctor.

Go ahead and give your opinions, doctor.

Q: Actually, my question, sir, is: Do you agree with Dr. Stockwell, having now read his deposition, that the only thing a little worrisome from the August 21 hospital stay is the blood pressure of 144 over 86?

You agreed with him on that?

A: I disagree.

Q: Do you agree that a blood

Page 111

S. R. INGLIS

pressure of 144 over 86 does not a diagnosis of preeclampsia make?

Do you agree with that with him?

A: I would say that a blood pressure of 144 over 86 is simply a blood pressure. It doesn't tell you whether it's preeclampsia or not. It could be preeclampsia, it could not be preeclampsia. It doesn't tell you whether it is or not.

Q: You would agree that a diagnosis of preeclampsia cannot be made based upon a blood pressure of 144 over 86.

True?

A: You can make the diagnosis of preeclampsia if you have a blood pressure of 144 over 86 and you have other things wrong with you, yes.

Q: That wasn't my question.

A: I know.

Q: Blood pressure of 144 over 86 does not make a diagnosis of preeclampsia.

True?

A: Simply one blood pressure of 144 over 86 by itself does not give you

Page 112

S. R. INGLIS

preeclampsia.

Q: One plus proteinuria is not particularly significant.

Do you agree with Dr. Stockwell in that regard?

A: If we're going to go through the same line of questions over and over again, one plus protein and one dip stick doesn't give you preeclampsia. It takes more than that to make the diagnosis. It takes more work.

Q: You don't have to get angry. I'm just trying to ask you your opinions.

You would agree with me with respect to one plus proteinuria, a 24-hour urinalysis will likely not demonstrate significant protein in the urine?

A: It depends on the definition of significant.

Q: What's your definition of significant?

A: Certainly anything over 300 milligrams.

Q: What do you believer is needed on

Page 113

S. R. INGLIS

qualitative analysis to achieve what you think is significant at 300 milligrams?

A: I'm not sure.

It's all statistically done. I mean, you could — you could have a dip stick of only one plus and end up with more than 300 milligrams; so, therefore, I would suggest that one be careful and check the 300 milligrams, make sure it's not 300 milligrams.

I don't think it's zero.

Q: You're certainly aware of the literature that would suggest that qualitatively it's a plus two or plus three that will likely correlate with proteinuria on a 24-hour urine specimen, not plus one.

You're aware of that literature?

A: The key word here is likely.

Q: That's what we're interested in here.

A: Likely is a good word, but generally in medicine we try to be sure. And if there's any doubt, you might want to consider doing the test to make sure.

MS. DiSALVIO: Madam court

Page 114

S. R. INGLIS

reporter, can you read my question back?

(Record read)

**Q:** Are you aware of that literature, sir?

**A:** I'm aware of it, yes.

**Q:** Do you disagree with it?

**A:** No, I don't disagree with it.

**Q:** Are you at all surprised that the literature suggests that where a urinalysis is negative for protein — a 24-hour urinalysis will likely be negative for protein?

**A:** I'm not surprised by that.

**Q:** Are you aware of that literature?

**A:** Not specifically, no, but it would not surprise me.

**Q:** You disagree with that proposition?

**A:** No, I do not disagree.

**Q:** Would you agree with me that prior to the September 16, 17 admission, Ms. McElfish's cervix was unripe?

**A:** I believe that to be the case, yes.

Page 115

S. R. INGLIS

**Q:** Do you agree with me that there was never any evidence of fetal compromise in this case?

**A:** Yes, I agree with that.

**Q:** Do you agree with me that there was no evidence of maternal end organ involvement in the prenatal assessment and management of this patient?

**A:** Could you repeat the question?

**Q:** I sure could. Would you agree with me that there was no evidence of maternal end organ involvement throughout this patient's prenatal course?

**A:** The only one I'm debating, on 9/8 there's a two plus protein, and I guess it depends on your definition of end organ.

**Q:** What's your definition of end organ?

**A:** Clearly, liver would be included. Clearly, hematological problems would be included.

Kidneys, I think classically are an end organ. They're an organ that gets

Page 116

S. R. INGLIS

damaged. So, if you want to include kidneys, then maybe that is one of them.

**Q:** Do you include it?

**A:** Yes.

**Q:** You would agree with me that there is no evidence whatsoever of kidney function abnormality in the prenatal period by way of BUN or creatinine.

True?

**A:** No, false. I already testified that I thought eleven for BUN was not normal.

**Q:** Okay. Let's go back there for a minute.

What's the lab reference range for the BUN you claim to be abnormal?

**A:** That won't be for pregnancy, it will be for someone forty years old and not pregnant.

**Q:** So, as I understand it, you believe that the reference range for the BUN for Sherry McElfish applies to a forty year old not pregnant individual?

**A:** It applies to the standard

Page 117

S. R. INGLIS

persons that are not pregnant.

**Q:** Can you tell me literature that says BUN of eleven is abnormal for proteinuria?

**A:** I can't.

**Q:** Do you know of any?

**A:** No.

**Q:** Then based upon the principals in the literature and in the ACOG technical and practice bulletins, would you agree with me that Sherry McElfish did not have any evidence of kidney end organ dysfunction based on BUN and creatinine in the prenatal period?

**MR. BECKER:** Objection. Asked and answered.

**A:** According to those documents you just listed, I guess it's not in there.

**Q:** So I would be correct. Yes?

**A:** For those specific documents, yes.

**Q:** Do you agree with me that this patient had an amniotic fluid embolus?

**A:** No.

Page 118

S. R. INGLIS

Q: Did you review the autopsy protocol?
A: I did a long time ago.
Q: Do you have it in your materials?
A: Maybe.
Q: Why don't you take a look for it?
A: I think I do.
Yes, I have it in front of me.
Q: I want to jump back for a moment.
We only addressed the kidney.
You agree with me that this patient had no other end organ involvement in her prenatal course.
True?
A: She frequently complained of headache, lights and stars, and so on. So, possibly she had neurological symptoms, possibly that is an end organ.
Q: I beg your pardon?
Is it your testimony that she had neurologic involvement?
A: Well, on 8/21 she complains of

Page 119

S. R. INGLIS

headache, visual symptoms, flashing lights and stars, while her blood pressure is 150 over 100. So, there's neurological symptoms. I don't know whether you would call those end organ.
Did you refer to end organ damage? Involvement?
So, I'm not sure.
Q: When we're talking end organ, do you believe that those are symptoms of brain end organ involvement?
Is that your testimony?
A: I'm not sure whether they would fit the definition. They might be an end organ. I don't know.
They certainly are not — it just depends on your definition of the brain, and then whether simply vasospasm would be an end organ involvement. It might be.
Q: Can you cite me to any literature to support that?
A: No, I can't.
Q: Would you agree with me that in all likelihood those symptoms do not represent

Page 120

S. R. INGLIS

brain end organ involvement?
A: Well, they certainly are part of the definition of severe preeclampsia, and we certainly take it very seriously, so maybe I should say they are end organ involvement and you need to deliver.
Maybe they are. I don't know the answer as to whether they are according to definition of an end organ. I don't know.
Q: Are you familiar with the ACOG expert witness affirmation?
A: Yes.
Q: Are you familiar with that document?
A: Yes.
Q: Are you willing to sign that document in connection with the opinions that you're giving here today and have your opinions peer reviewed by members of the American College?
A: I don't know.
Q: You don't know what, sir?
A: I don't know what that has to do with this discussion.

Page 121

S. R. INGLIS

Q: Are you willing to have the opinions that you're giving here today reviewed by your peers in the American College of Obstetrics — of Obstetricians and Gynecologists?
A: They probably are able to right now.
Q: Are you willing to submit them for review?
A: I don't have any choice; you can submit them whenever you want.
Q: Are you go willing to sign an affirmation relative to your opinions?
A: I have to think about it.
Q: Very good.
You were looking at the autopsy.
Can you look at the lung assessment for me?
A: I don't see it.
Do you know what page it's on?
Q: If you don't have it, tell me you don't have it. That's fine too.
A: Yes, I actually see it now on page three.

Q: Are there any findings there that indicate amniotic fluid embolus?
A: It says trophoplastic emboli.
Q: What does that suggest to you?
A: It suggests the pathologist that did the autopsy thinks there may have been trophoplastic emboli.
Q: That's an amniotic fluid embolus. Yes?
A: No.
Q: So you would disagree with Dr. Stockwell, who states that there is, indeed, evidence of amniotic fluid embolism based upon precisely what you just read.
You disagree with him in that regard?
A: I believe that we only have trophoplastic emboli, and that does not equal amniotic fluid embolism as in a clinical disorder.
Q: So, you would disagree with Dr. Stockwell.
Yes?
A: Yes.





Q: Do you agree that one is unable to predict or prevent an amniotic fluid embolus?
A: Yes.
Q: Do you agree that difficult breathing and a sudden drop in blood pressure are consistent with a diagnosis of amniotic fluid embolism?
A: Yes.
Q: Do you agree that amniotic fluid embolus is the leading cause of death during labor and the several hours postpartum?
A: No.
Q: Do you rule out amniotic fluid embolism as causing or contributing to Sherry McElfish's death?
A: No, I don't rule it out.
Q: Do you agree that the development of superimposed preeclampsia is common in patients with hypertension and often difficult to diagnose?
A: Yes.
Q: Do you agree that women with mild hypertension as defined by 140 to 179 over 90





to 109 generally do well during pregnancy and do not require anti-hypertensive medication?
Do you agree with that?
A: Could you say it one more time?
Q: Women with mild hypertension as defined systolic 140 to 179, diastolic 90 to 109, generally do well during pregnancy and as a rule do not require anti-hypertensive medication.
Do you agree with that?
A: I would suggest that patients with blood pressure over 160 systolic and diastolic over 105 may benefit from hypertensive therapy, but the rest of it I agree with.
MS. DiSALVIO: Do you need to take a break?
THE WITNESS: Yes, can I?
(Recess taken)
Q: Doctor, I want to jump back to September 5 for a minute.
Do you agree while the patient was in hospital on September 5 that all labs were normal, blood pressures were normal, and





there was negative urine protein?
Do you agree with that?
A: Yes.
Q: Do you agree that there is no data, no scientific evidence, that anti-hypertensive medication will improve perinatal outcome?
A: Yes, I do agree with that.
Q: Do you agree that the majority of pregnant women with chronic hypertension have uncomplicated hypertension and can be managed the same as normal nonhypertensive women during the intrapartum period?
A: Could you state that one more time for me?
Q: Sure.
Do you agree that the majority of pregnant women with chronic hypertension have uncomplicated hypertension and can be managed the same as normal nonhypertensive women during the intrapartum period?
A: Does the majority mean greater than fifty percent?
Q: Yes.

Page 126

S. R. INGLIS

A: Yes, then.
Q: Are you licensed to practice medicine?
A: Yes.
Q: Do you spend greater than fifty percent of your time in the active clinical practice of medicine or its teaching?
A: Yes.
MS. DiSALVIO: I'm going to pass the baton to my colleagues and see if they have any other questions while I review my notes.

EXAMINATION
BY MS. REID:

Q: My name is Christine Reid, and I represent Euclid Hospital in this case and just have a couple of questions for you.
First of all, I think we established that in your opinion a blood pressure of 130 over 80 is not a normal blood pressure for a pregnant patient.
Correct?
A: Yes.
Q: What is your definition of a

Page 127

S. R. INGLIS

normal blood pressure during pregnancy?
A: Probably 120 over 70 would be normal.
It really depends on the age of the patient. If she is 16 and you have a blood pressure of even 120, that's questionable; if she's 45, then that might be normal for her.
Q: Let's say in a 27 year old patient, what's a normal blood pressure during pregnancy?
A: I would say a normal would be 120 over 70. It wouldn't raise a flag for me to do anything special.
Q: If a patient has a blood pressure of higher than 120 over 70, is that in your practice given a work-up for preeclampsia?
A: No, I don't think it has to. I think it needs to be monitored carefully and it has to be considered that if you have any further trouble with her blood pressure, that she will need a work-up for chronic hypertension just to make sure there's nothing wrong with her kidneys to get a

Page 128

S. R. INGLIS

baseline.
Q: At what point would you get this baseline study, then?
A: You're talking now specifically this case?
Q: No, I'm talking about in your practice with the 27 year old patient who initially presents with a blood pressure above 120 over 70.
A: Right. I think it would be reasonable to leave her alone and not do it when she first does —
You want to make it a blood pressure of 130 over 80, is that the number you want to pick?
It might be easier to do it that way.
Q: Sure.
A: In that case, then I think it would be reasonable to not do a work-up the first time you get a 130 over 80, but I would suggest the — when you continue the pregnancy, you watch the blood pressure. And

Page 129

S. R. INGLIS

if the blood pressure starts to climb even higher, then I would suggest at some point you need to do a baseline work-up to see how the patient's doing. And then you could use that later on in pregnancy to determine whether she's, indeed, developing preeclampsia or whether she has a baseline renal problem or renal disease.
Q: Doctor, it seems to me in listening to your testimony and reviewing your report that your criticisms of the care and the care providers in this case end at about 2:30 a.m. on the 17th.
Is that correct?
A: I don't know how to answer that question. Tell me what you mean by that question.
Q: Well, do you have any criticisms of any care that was provided after 2:30 a.m. on September 17 — or is it September 18?
No, September 17, I apologize.
A: Well, I think that she at 2:30 needed everything that she needed earlier. She still needed to be under very intensive

monitoring, most likely in an intensive care unit setting where they can do everything, and check labs very frequently, et cetera.

**Q:** Is it fair to say now that you've been questioned by everyone in this case that we've covered either through your report or deposition testimony all of your opinions in this case?

**A:** I think we have, yes.

**Q:** Have you ever been sued for medical malpractice, Dr. Inglis?

**A:** Yes.

**Q:** On how many occasions?

**A:** It must be two, but I clearly have been sued at least once.

**Q:** What county were those lawsuits in?

**A:** It's in the City of Albany in New York.

**Q:** Both of them?

**A:** Actually, I can remember better now. There was one suit in Albany, and there was — then I was dismissed from — no, there's only one that I can clearly tell you,





and that's in Albany where I was sued.

**Q:** About what year was that?

**A:** That would have been 19 — probably 1989.

**MS. REID:** That's all the questions I have. Thank you.

**MS. DiSALVIO:** I have more when everybody's done.

**MR. AUCIELLO:** I have no further questions.

**MS. DiSALVIO:** Ernie, do you have any more?

**MR. AUCIELLO:** No, I'm done.

**EXAMINATION**

**BY MS. DiSALVIO:**

**Q:** Doctor, I just have one last one. In your report, you set forth your criticisms, if I'm correct, at pages five, six, seven, and eight.

Yes?

**A:** Yes.

**Q:** And in those criticisms, you have not articulated any criticisms relative to the assessment or the confinement of September 5.





True?

**A:** I think it was implicit that the same remarks regarding 8/21 would apply to 9/5.

**Q:** It's not in your report. True?

**A:** It may not be there.

**Q:** Take a moment. Point it out to me if it's there.

**MR. BECKER:** It's on page six, paragraph eight.

**MS. DiSALVIO:** I'm sorry, who's talking?

**MR. BECKER:** Mike is talking.

**MS. DiSALVIO:** What did you say?

**MR. BECKER:** I said page six, paragraph eight.

**MS. REID:** Is that the answer to the question?

**MR. BECKER:** I'm trying to move it along.

I understand the question is: Did you reference 9/5 at any time?

**Q:** Actually, the question is: Did





you reference the confinement and evaluation in the hospital of September 5 in your report?

**A:** Possibly, yes.

If you look at number eight, it says no effort was made to rule in or rule out superimposed preeclampsia from 9/5 to 9/16 in terms of doing 24-hour urine or bloodwork to check platelets or liver function.

**Q:** Let's go to September 5. You reviewed the admission?

**A:** Yes.

**Q:** And I think you've already agreed with me that the urinalysis was negative for protein during that confinement.

**A:** I believe, yes.

**Q:** All blood pressures obtained during that confinement were normal. Correct?

**A:** Yes.

**Q:** Feel free to look.

**A:** You're right.

**Q:** And some labs were done. Yes?

**A:** Yes.

Page 134

S. R. INGLIS

Q: And those labs were normal?
A: Correct.
Q: What labs were done?
A: I believe — I'm sure liver functions were done, uric acid were done.
I'm not sure if a CBC was done that day.
Q: The labs you say should have been done were, indeed, done on this date?
A: Well, no.
The statement that you're reading is a generic statement, and, so, it's saying that —
Q: I can't hear you.
A: The statement you're reading here is a generic statement saying there was no 24-hour urine done on any of those occasions.
Q: I want to talk about September 5 and my client Dr. Karasik.
You don't have criticisms of the way Dr. Karasik managed and evaluated this patient for his limited contact in hospital on September 5.
True?

Page 135

S. R. INGLIS

A: Let me make sure it's clear.
Dr. Karasik was, like, the house physician doing the nonstress test or the person who was responsible for that patient?
Q: On September 5, he was the physician who was attending to the patient in hospital.
You would agree with me that he obtained the appropriate lab studies.
True?
A: Did Dr. Karasik refer the patient in from the clinic to the hospital.
Q: No.
A: Someone else did?
Q: He was the receiving physician at the hospital.
A: Right.
Did he work with Dr. Bailin?
Is he one of his partners?
Q: Does it matter to you, sir?
A: Yes.
Q: Why?
A: Because whoever referred in the patient is the one who makes the decisions as

Page 136

S. R. INGLIS

to what exactly — how they want that patient evaluated. If Dr. Karasik is simply the person in there doing nonstress tests and checking the blood pressure, then I think his care was fine.
But whoever referred the patient in from the clinic with a blood pressure of 160 over 86 should have requested more work be done.
Did I answer the question?
Q: Yes.
What additional work?
A: Admit to the hospital for at least 24 hours, check the blood pressure, do a 24-hour urine, do the labs that they did and maybe repeat the labs that they did, and, if the blood pressure was still high, keep her in the hospital.
Q: And if the blood pressure was normal, the 24-hour urine was normal, and the labs are normal, it's appropriate to discharge.
Yes?
A: If all of the subsequent blood

Page 137

S. R. INGLIS

pressures were normal, and, as you say, all the laboratory work was done and was normal, then you could consider discharge. She would need very careful follow-up in terms of her blood pressure because just earlier that morning she had a very high blood pressure, but she could be discharged.
MS. DiSALVIO: Of course she could.
Okay. I don't think I have any other questions.
MR. TREU: Nothing here.

(Time noted: 5:15 p.m.)

Page 138

CAPTION

The Deposition of STEVEN R. INGLIS, M.D., taken in the matter, on the date, and at the time and place set out on the title page hereof.

It was requested that the deposition be taken by the reporter and that same be reduced to typewritten form.

Page 139

CERTIFICATE

STATE OF :
COUNTY/CITY OF :

Before me, this day, personally appeared STEVEN R. INGLIS, M.D., who, being duly sworn, states that the foregoing transcript of his Deposition, taken in the matter, on the date, and at the time and place set out on the title page hereof, constitutes a true and accurate transcript of said deposition.

STEVEN R. INGLIS, M.D.

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

My Commission Expires Notary Public

Page 140

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:**

I have read the entire transcript of my Deposition taken in the captioned matter or the same has been read to me. I request for the following changes to be entered upon the record for the reasons indicated.
I have signed my name to the Errata Sheet and the appropriate Certificate and authorize you to attach both to the original transcript.

**SIGNATURE: DATE:**
STEVEN R. INGLIS, M.D.

Page 141

INDEX



EXHIBITS



REQUEST FOR DOCUMENT PRODUCTION

CERTIFICATE

STATE OF NEW YORK )
)ss.:
COUNTY OF NEW YORK )

I, LINDA A. MARINO, a Registered Professional Reporter, Certified Shorthand Reporter, and Notary Public within and for the State of New York do hereby certify:

I reported the proceedings in the within-entitled matter to the best of my ability, and that the within transcript is a true record of such proceedings.

I further certify that I am not related, by blood or marriage, to any of the parties in this matter and that I am in no way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this day of 2005.

LINDA A. MARINO, RPR, CSR

## Lawyer's Notes

## D

## I



## J



## K



## L



## M

## N



## O



## P

## Q



## R

## S

## T



## U



## V



## W



## Y



## Z

## Lawyer's Notes