State of Ohio,)
) SS:
County of Cuyahoga.)

- - -

IN THE COURT OF COMMON PLEAS

- - -

Damien Spearman, Jr., etc., et al.,
Plaintiffs,
vs.
James Izanec, M.D., et al.,
Defendants.
Case No. 314977

- - -

DEPOSITION OF JAMES J. IZANEC, M.D.

FRIDAY, FEBRUARY 14, 1997

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The deposition of James J. Izanec, M.D., a Defendant herein, called by the Plaintiffs for examination under the Ohio Rules of Civil Procedure, taken before me, Ivy J. Gantverg, Registered Professional Reporter and Notary Public in and for the State of Ohio, by agreement of counsel and without further notice or other legal formalities, at the offices of Reminger & Reminger, 113 St. Clair Building, Cleveland, Ohio, commencing at 9:05 a.m., on the day and date above set forth.

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APPEARANCES:
On behalf of the Plaintiffs:
Michael F. Becker, Esq.
Suzanne Veverka, R.N.
Becker & Mishkind
134 Middle Avenue
Elyria, Ohio 44035
On behalf of the Defendants:
Gary H. Goldwasser, Esq.
Reminger & Reminger
113 St. Clair Building
Cleveland, Ohio 44114

Also Present:

Genevieve McCaslin, C.N.M.

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JAMES J. IZANEC, M.D.
a defendant herein, called by the plaintiffs for examination under the Rules, having been first duly sworn, as hereinafter certified, was deposed and said as follows:

CROSS EXAMINATION

BY MR. BECKER:

Q. Good morning. Would you tell me your full name, please?
A. James J. Izanec.
Q. What is your home address, sir?
A. 28299 Fairmount, that is F-A-I-R-M-O-U-N-T, Boulevard, Pepper Pike, Ohio, 44124.
Q. What is your business address?
A. 12000 McCracken, M-c-C-R-A-C-K-E-N, Road, Garfield Heights.
Q. What is the name of your professional group?
A. South Suburban Women's Center.
Q. Are you an owner of that professional group?
A. Yes, I am.
Q. Who are the other owners of that professional group?
A. John J. Farinacci. He spells his last name F-A-R-I-N-A-C-C-I.
Q. Anybody else?

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A. No.
Q. Have you ever had your deposition taken before?
A. Yes.
Q. I just want to review some things, some ground rules, before we begin.
This is a question and answer session under oath. It is important you understand the question that I ask you.
If the question is inartfully phrased or doesn't make any sense, you tell me and I will attempt to rephrase or restate the question, fair enough?
A. Yes.
Q. However, unless you indicate otherwise to me, I am going to assume that you have fully understood the question, okay?
A. Yes.
Q. It is also important that you answer verbally, because it is difficult for Ivy to pick up a head nod, all right?
A. Yes.
Q. Tell me what you have reviewed in preparation for this deposition?
A. I have reviewed Ms. McClain's chart, the admission note of Dr. Stork, and the ACOG Technical

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Bulletins for -- I don't recall the titles, it is the bulletin which concerns infection in obstetrics and gynecology, and the bulletin which has actually since been retracted on Group B Strep.
Q. It has been retracted?
A. It has been retracted.
Q. When was it retracted?
A. I don't recall the date, sir.
Q. Within the last few months, very recently?
A. Sometime during 1996, sir.
Q. I didn't know that.
Go ahead.
A. And the ACOG committee opinion on treating Group B Strep in pregnant women prophylactically.
Q. Anything else?
A. I can't recall that. No.
Q. Why did you look at the ACOG Technical Bulletins and the committee opinions?
A. Because those are summaries of the current opinions of some of the learned people in the field of obstetrics and gynecology.
MR. BECKER: Have you provided me a vitae on this doctor?
MR. GOLDWASSER: I don't know.
MR. BECKER: He may have, and I

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probably --
THE WITNESS: Sure, sure.
MR. GOLDWASSER: I have one with me, but I thought I gave it to you with answers to interrogatories. Perhaps not.
MR. BECKER: Probably. It seems I consistently do this.
MR. GOLDWASSER: I have one here, but it is the only copy I have. You can use it for today's depo.
MR. BECKER: Okay, fine.
(Thereupon, the document was handed to Mr. Becker.)
MR. BECKER: Do you mind if I mark it as an exhibit?
MR. GOLDWASSER: I don't mind.
We will make a copy of it before you leave.
MR. BECKER: Mark that, Ivy, please.
(Thereupon, Plaintiffs' Exhibit 1 (Izanec) was marked for identification.)
BY MR. BECKER:
Q. Doctor, I am handing you now what has been marked as Exhibit 1, Izanec Exhibit 1. Would you take a look at that first and tell me what it is?

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A. It is my curriculum vitae.
Q. And is it current?
A. Yes, it is.
Q. Doctor, on this vitae, it reflects a certificate for "practice of healing heart." What does that mean?
A. That is --
Q. Is that the same thing as a medical license?
A. Yes, sir, it is. That is the --
Q. For the District of Columbia?
A. -- description for the District of Columbia, yes.
Q. You are currently associated with Case Western Reserve University as a clinical instructor, correct?
A. Sir, that is incorrect. I have not been an instructor for about two years.
Q. Okay.
When you were an instructor, what were you doing?
A. I was teaching medical students in the family clinic one afternoon a week.
Q. What would you be teaching them in the family clinic?
A. We were seeing women who were pregnant, and

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they were coming in for their ante partum visits, and I was supervising.
Q. Now, what was the reason you stopped doing this?
A. Because I had other time demands.
Q. You are Board certified in OB/GYN?
A. Yes, sir.
Q. Did you pass the examination the first time you took it?
A. Yes, sir.
Q. Now, currently, how many other employees are there of your professional group?
A. I don't understand the breadth of the question. Does that include clerical people?
Q. I am sorry, poor question. I will ask it again.
I want to know, besides your partner, who you have identified already, are there other physicians that work for the professional group?
A. Yes.
Q. Who are they?
A. William Grossman.
Q. Anyone else?
A. No.
Q. Tell me who the midwives are that work for

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the group?
A. There is Genevieve McCaslin, and Judy Kreye. That is spelled K-R-E-Y-E.
Q. At the time that this child was born, were there any other employees of the group?
A. No.
Q. Back in May of 1995, how was your health?
A. Fine.
Q. You weren't under any kind of a disability, either physical or mental, back in May of 1995?
A. No, sir.
Q. Which textbooks in fetal monitoring would you consider to be the most reliable in obstetrics today?
A. I don't have an opinion about that, sir.
Q. Are there any textbooks in obstetrics that you would consider authoritative?
A. How would you define authoritative?
Q. That you would consider the best, absolutely reliable, that there is a consensus among your peers that it is considered the best.
A. I don't believe that there is any textbook that would have a majority.
Q. Okay.
How about journals, medical journals, are

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there any journals that you would consider reliable, that you would turn to first in the subject of fetal monitoring?
A. I am having a problem with your question because of the word, reliable.
Q. Okay, I will move on, Doctor.
You have indicated you have had your deposition taken before. You have had other claims presented against you before?
A. Yes.
Q. I want to talk about those claims. I am interested not so much in the identity of those claims right now, but I am interested in the subject matter, medical subject matter.
Can you just kind of highlight the claims over your career for me?
MR. GOLDWASSER: Objection.
You may answer.
A. Well, there has been one. And that involved a child which was found to have a cerebral infarct at thirteen months of age, and was found to have weakness --
Q. Hemiplegia?
A. -- on its right side.
Sir, the description of the child's problem,

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to me, is so vaguely defined, that I am giving you my most precise answer.
Q. Is the allegation that this came about via your management of labor and delivery?
A. Yes.
Q. Is that case still pending currently?
A. Yes.
Q. Do you know the name of the plaintiff's attorney?
A. William Novak.
His first name is William?
MR. GOLDWASSER: Yes.
Q. Did you use any instruments in that delivery --
MR. GOLDWASSER: He is not going to answer any questions as relates to the substance of that case. He is instructed by me that he will not discuss that case. The case is pending. We are not going to have two trials in one here.
Q. (Continuing) Other than that case, any other cases?
A. No.
Q. Through your whole career?
A. You stated that I have given depositions for?
No.

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Q. Any cases where you have not given deposition for, maybe the case was most probably dismissed then?
A. Yes.
Q. So we have covered the cases that have been filed against you, where there has been a deposition?
A. Yes, sir.
Q. Now, tell me a little bit about Nurse Midwife McCaslin, how long has she been with your group?
A. Three years.
Q. Where had she been prior to coming on board with your professional corporation?
A. She was working with Dr. Stephen Luczek, L-U-C-Z-E-K.
Q. Was she the first midwife you hired --
A. Yes.
Q. -- for your professional group?
A. Yes, sir.
Q. And what is the philosophy within your office as to how you best utilize midwives, how you want to utilize midwives within your office?
A. We are using them within their scope of expertise, scope of training, and they are taking care of their own patients who identify them as

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their primary care giver, and they will also assist us with our own pregnant patients.
Q. Are they utilized to manage actual labor and deliveries of your patients at various hospitals, assuming there is no high risk factor or complication?
A. Yes.
Q. Can you give me some examples of a complication or risk factor, based on your rules within your office, or the rules within the hospital, as to when you have to become actively involved in the management of the particular labor and delivery?
MR. GOLDWASSER: Rather than a midwife.
A. Sure.
If the woman is in premature labor, we would be actively involved. If the child is presenting in a malpresentation, such as a breech presentation, we would be involved.
Q. Okay.
A. If there were problems such as pregnancy induced hypertension, we would be involved.
We would also co-manage problems. If there was meconium stained fluid, you know, that, in and

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of itself, there would certainly be the co-management.
Q. What about a history of polyhydramnios, would that kick in an automatic co-management situation?
A. That would depend on the severity of the polyhydramnios.
Q. Are there different levels of severity, either mild, moderate, or severe?
I am not familiar with --
A. It is not graded using those terms --
Q. Right.
A. -- but some people will have three, four, five liters of fluid within their amniotic sac. That will present many problems. But for smaller amounts, no.
Q. What about if fetal distress develops during the course of labor, does that demand co-management?
A. Yes, sir.
Q. Would you kind of define for me what co-management means, if you are not in the hospital, and fetal distress develops, what your responsibility is?
A. If fetal distress develops, then if we are not in the hospital, and the midwife was to contact us --

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Q. Okay.
A. -- we would then come up with a plan of action, and then we would follow through with that plan.
Q. Would that be reduced to writing somewhere, the plan of action?
A. The specific plan of action may or may not be reduced to writing under the caption, this is the plan of action. But as the activities occur, that should all be very clear.
Q. Jumping ahead to this case, the McClain case, was there ever a plan of action developed between you and Midwife McCaslin?
A. Yes.
Q. When was that developed, what time, what day?
A. It was developed on the -- we began talking about it at 5:30 on May the 27th, on the day that the baby was born.
Q. What do you recall about the terms of that plan of action, the details of it?
A. This case changed over time, changed over time. And so we were constantly updating, taking into account the new developments as they were happening.
May I look at the chart?

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MR. GOLDWASSER: Of course, absolutely.
Q. Listen, Doctor. At any time during the course of this deposition, you are more than free to look at the chart before responding to any question. I want you to feel free to do that.
A. Yes, yes.
I believe that I remember these details, but I don't want to --
MR. GOLDWASSER: Doctor, you don't have to give excuses. Just look at the record and answer the questions as best you can.
A. (Continuing) At 5:30 on the 27th, I was made aware of the mother's temperature, Ms. McClain's temperature elevation, and also of the fetal monitoring patterns. And --
Q. Do you recall -- excuse me, I didn't mean to interrupt you -- specifically what you were told by this midwife relative to the fetal monitoring patterns?
A. No, I don't.
Q. Go ahead.
A. And at that time, she was also seven to eight centimeters dilated, and the thought was that at

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that time, you know, she would continue to be followed very carefully, the pattern assessing the well being of the fetus, and the hope was that she would be delivering within a few hours. So then that is what we were doing at that time.
Q. So the plan at 5:30 that was developed consisted of continued monitoring by the midwife without your presence, correct?
A. Yes.
Q. And since the mom had reached six or seven centimeters, that you were hopeful that the baby would be delivered within a few hours?
MR. GOLDWASSER: Seven to eight, I believe.
Q. (Continuing) I am sorry, seven to eight centimeters.
A. Yes.
Q. That was, in essence, the plan?
A. And then once the baby would be born, then the baby would be assessed, because there was the possibility that infection was developing. And then the baby would be cultured -- assessed, cultured, and if need be, treated with antibiotics at that time.
Q. Based on the data you received at 5:30, did

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the concept of chorioamnionitis come in within your differential?
A. Yes.
Q. Was it within the midwife's differential at that time, as well?
MR. GOLDWASSER: You only know if she told you.
Q. (Continuing) Just what she told you.
A. You know, that, I don't recall.
Q. Back in May of '95, what was your practice, Doctor, relative to utilizing prophylactic antibiotics?
A. We did not use that at that time. For -- well, pardon me. We used that if there was a history -- pardon me -- if the person was in premature labor, if she had a history of having had a prior pregnancy where the child was infected with Group B Strep, if she had a Group B Strep, a urinary tract infection during that pregnancy, and also if there was a maternal temperature elevation early in the labor, if we anticipated that delivery would not be for many, many hours.
Q. And I am gathering, then, because you anticipated delivery within a few hours, and because she didn't have those risk factors that you have

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just enumerated --
A. Yes.
Q. -- you felt that setting up IV antibiotics, at least prophylactically, was not indicated based on your practice?
(Thereupon, a discussion was had off the record.)
A. Would you mind repeating that question again?
MR. GOLDWASSER: Ivy, please read it back.
(Record read.)
A. (Continuing) Yes.
Q. Now, jumping ahead to this case again, Doctor, my recollection is at 5:30, you told Nurse McCaslin that you were coming in.
A. Yes.
Q. When were you planning on coming in?
A. During that next hour.
Q. Did you tell her that you would be there within an hour?
A. I don't recall the time frame that I would have mentioned to her.
Q. Did you actually come in within the hour?
A. No.
Q. Why not?

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A. I don't know, sir.
Q. When did you actually arrive to assess the patient?
A. 7:30.
Q. Between that phone call by Nurse McCaslin to you at 5:30, and the time you arrived at 7:30, did you have any other contact with Nurse McCaslin?
A. I don't recall.
Q. Do you remember any phone call from her or someone on her behalf looking for you?
A. No.
Q. Do you recall contacting the hospital or Nurse McCaslin during that period of time, and giving a message to someone to get to Nurse McCaslin that you would not be there within the hour?
A. No.
Q. You were home when you were contacted at 5:30?
A. I don't recall.
Q. Maybe we should review, Doctor, in essence, what you do recall about this particular night and morning delivery, labor and delivery.
I am interested to know what your independent recollection is. If you think about this case, what comes to mind?

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MR. GOLDWASSER: I am going to object to that, Mike, for the following reasons, and then we can proceed.
Number one, the doctor has spent a good deal of time reviewing this chart. I think it would be next to impossible for anybody to sort out what he remembers from reviewing the chart, and independent memory.
Secondly is that it is such a broad question, contrary to the rules that we have a question and then an answer.
I certainly would permit him to talk about what he recalls by independent memory, but I am not sure he can do it in the context that you put the question.
Q. (Continuing) All right, with that objection or caveat, do the best you can, Doctor.
A. I do remember seeing Ms. McClain, and Ms. McCaslin, at about 7:30. And I recall vaguely, you know, discussing the case, reviewing the fetal monitoring strip at that time.
Q. Okay.
A. You asked about the 7:30 time?
Q. Well, I asked about that day.
A. Oh.

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Q. That labor, that delivery.
A. Okay.
After that, I went to the operating room at Marymount, and we were in surgery on this one case --
MR. GOLDWASSER: Remember, this is independent memory, not what you have learned in the last week, okay?
THE WITNESS: Okay.
MR. GOLDWASSER: That is why I objected to the question. You have to be careful. I don't want you to start talking about what you have learned since you started preparing for this case.
THE WITNESS: Okay.
A. (Continuing) Well, then, there is this time, and then I recall coming back up to the labor floor at about 11:00, 11:30, I don't recall the precise time. We reviewed the monitor strip again, and the baby's head was crowning, the baby was going to be born very soon after that.
Q. Doctor, I am gathering in the answer you have just given me, that you had another case that morning, you have learned?
A. Yes, yes.
Q. What kind of case was it?

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A. It was a gynecologic operative case, a woman with pelvic pain, with ovarian cysts.
Q. What time did that surgery start?
A. 8:05.
Q. And what time did that surgery complete?
A. 10:20.
Q. It was an elective surgery?
A. It is what we call urgent.
Q. Could it have been postponed a few hours?
A. Yes.
Q. Did the patient come in -- the patient that you operated on for this GYN problem, was she in the hospital, or did she come in for the surgery that day?
A. She came in for the surgery that day.
Q. If you are in surgery, is your practice such that your partner takes over management of labor and delivery while you are in surgery?
A. If it is required, yes.
Q. What do you mean, if it is required?
I mean, if there is a need for an obstetrician, and you are in surgery, is your partner then available?
A. Yes.
Q. So you never schedule surgery for both of

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you, your office never schedules surgery for both of you at the same time; is that fair?
A. Yes.
Q. And while you were in surgery, do you recall receiving any type of contact from Midwife McCaslin as to the status of this case?
A. No, I don't.
Q. Would it be fair to say that you completed this GYN surgery, and then went back up to the floor to check on your labor and delivery patients?
A. Yes.
Q. Doctor, I want to define some -- I want you to define some terms for me that we are going to be using throughout the balance of this deposition.
Some people, obstetrical people, use the term fetal distress, some people use nonreassuring patterns. What is your practice?
MR. GOLDWASSER: In the context of what?
Q. (Continuing) In the context of fetal heart monitoring.
Do you use the --
A. I use both terms, sir.
Q. Tell me what fetal distress means to you, and distinguish that, then, from a nonreassuring

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pattern?
A. Fetal distress means that the pattern indicates that the fetus is not compensating properly to the stresses of labor. And nonreassuring is a -- it is more of a vague term, or it is a vaguely defined term that is a pattern which is not normal, which may be showing signs of fetal distress which is unclear at that time.
Q. Can you give me some examples of fetal distress, under fetal heart tracing patterns, can you give me some examples?
A. Oh, sure. A fetal bradycardia, a heart rate in the 80s or 90s, which is continuing that way for fifteen minutes, thirty minutes.
Q. Do you define bradycardia as anything less than 120?
A. Yes, sir.
Q. Go ahead, give me some more examples?
A. A fetal tachycardia, where the heart rate is consistently above 180, again for fifteen minutes, thirty minutes.
Q. Some people -- excuse me.
Some people define tachycardia as 160 and above. Do you disagree --
MR. GOLDWASSER: 116?

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MR. BECKER: 160 and above.
Q. (Continuing) Do you disagree with that concept?
A. I was talking about fetal distress. Fetal tachycardia, strictly speaking tachycardia, 160, sure.
Q. Okay.
A. Sure, yes.
Q. And we have talked about bradycardia, tachycardia. Let's talk a little bit about deceleration patterns.
Can you give me some examples of deceleration patterns that reflect fetal distress?
A. Persistent late decelerations, which again are going on for thirty minutes, sixty minutes, which is not responding to --
Q. Intrauterine resuscitation?
A. -- therapeutic methods.
I don't know the term, intrauterine resuscitation.
Q. When I use that term, I am referring to the change in position of the mom, administration of oxygen, pushing the fluids, that kind of thing.
A. Okay.
Q. We have talked about late decelerations. Any

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other type of deceleration pattern that you would consider fetal distress?
A. Frequently, sir, the patterns have to do more with the entire episode that is happening.
Q. You have got to look at the big picture, right?
A. The big picture.
Q. All right, let's talk about variability.
Can that reflect --
MR. GOLDWASSER: You are talking about beat to beat variability?
Q. (Continuing) Right, beat to beat variability.
Can that reflect fetal unwell being or fetal distress?
A. I think that usually will reflect evidence of fetal stress, not necessarily distress.
Q. What do you mean -- would you distinguish fetal stress from fetal distress?
A. Fetal stress is the fetus responding to the physical stressors of labor, the change in blood flow through the uterus with contractions, the changes to the fetus, to its autonomic nervous system, with the contractions, with head compression.
You know, there is maternal hypertension.

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That again will change blood flow. If there is a maternal temperature elevation, that will again change the circulation.
Those types of things will stress the baby.
Q. You don't feel that a decrease in variability can be an indicator of fetal distress?
A. It can be, but in and of itself --
Q. Okay.
A. -- usually not, usually not.
Q. Some people believe that variability reflects -- indirectly reflects the brain status of the fetus. Do you believe that?
A. It is certainly controlled by the autonomic nervous system, yes.
Q. That is why I asked, when you said that.
Some people believe that a decrease in variability can be an indication that the fetus is becoming acidotic. Do you agree with that concept?
A. That sometimes occurs, yes.
Q. And of course, if the fetus is becoming acidotic, that is an indication that there is some oxygen deprivation going on within the labor process, correct?
A. That would be one cause for that, yes.
Q. Can you give me some examples of other

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causes, besides oxygen deprivation, to lead to acidosis in a fetus?
A. The mechanics of the blood flow through the uterus and then through the placenta will involve the uptake of oxygen by the fetus and the clearing of CO2 by the fetus going the other way. So again, depending on all of those mechanisms.
Q. Okay.
I want to explore your recollection of conversations, Doctor, with Nurse McCaslin, Midwife Nurse McCaslin, throughout the labor and delivery.
MR. GOLDWASSER: Are we talking about now independent, again, of the chart?
Q. (Continuing) Yes, anything that is not reflected in the chart.
Do you have any other recollection of conversations with her?
A. No, sir.
Q. Do you have any recollections of talking to her after this child was born?
A. We were both very surprised that the child was as sick as it actually was, very surprised.
Q. Would it be fair for me to conclude that neither you nor Nurse McCaslin, to your knowledge,

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anticipated a depressed newborn?
A. Yes.
Q. And had you anticipated a depressed newborn, you would have had respiratory therapy and/or a pediatrician or the Code Pink team in attendance?
A. Oh, yes.
Q. That would be the standard of care, if there was reason to anticipate --
A. (Witness nods).
Q. -- you are nodding your head -- if there is reason to anticipate a depressed newborn, the standard of care requires of you, as well as Nurse McCaslin, to have a respiratory team in at the time of delivery, correct?
A. To have the neonatologist present, yes.
Q. You have just indicated that you and Nurse McCaslin were both very surprised at the condition of this child at the moment of birth; is that accurate?
A. Yes, sir.
Q. After this child was born and was resuscitated and taken away to University Hospital, did you have an opportunity to sit down with Nurse McCaslin and jointly review the fetal monitoring strips again?

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A. That, I don't recall, sir.
Q. Would that be something you likely would have done?
A. Yes, yes.
Q. And as you sit here, I appreciate that she is your employee, but I must ask you, do you have any criticism of the way -- in retrospect, in the way that Nurse McCaslin managed this particular labor?
A. No.
Q. Prenatally, did you see this particular mom?
MR. GOLDWASSER: Here are the prenatal records.
(Thereupon, the document was handed to the witness.)
A. I did not.
Q. Was your partner in town at the time of delivery?
A. I don't know that, sir.
Q. I am gathering that you were at least on call for the group --
A. Yes.
Q. -- during that night --
A. Yes.
Q. -- as well as the next day?
A. Yes.

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Q. Doctor, did you generate any notes as a result of this particular labor, as a result of any contacts with Nurse McCaslin via phone or in person as a result of this particular delivery, that are not contained in the hospital chart?
A. No, sir.
Q. Do you have a practice, Doctor, as to your calls at home, that you write down who called you, and when you were called?
A. No, sir, I don't.
Q. Would it be fair for me to conclude that the first time you became aware that this patient was admitted to Marymount Hospital was at 5:30 on the 27th of May?
A. Yes, sir.
Q. There is not a practice in your office, between the obstetricians and the midwives, that if a patient comes in, to at least notify you that one of your patients is in labor?
A. The practice of the labor floor is to notify the first person on call. And that person would have been Ms. McCaslin.
MR. GOLDWASSER: The facts are, Dr. Farinacci saw this patient about an hour and a half after she was admitted. So it

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wasn't like the group didn't know.
MR. BECKER: Right.
A. (Continuing) Yes, well --
MR. GOLDWASSER: That is enough.
A. -- of course --
MR. GOLDWASSER: Stop.
Q. Did you have an opportunity to look at the strips from the NST performed on May 26th?
A. Yes.
Q. Do you feel they were assuring or reassuring, or reactive or nonreactive?
MR. GOLDWASSER: Take your time, if you want to pull them out of there.
A. This is a reactive non-stress test, sir.
Q. Okay.
You indicated that you actually first saw the patient at approximately 7:30 in the morning, correct?
A. Yes, sir.
Q. And either based on your memory, or based on the chart, let's review each and every thing you did at 7:30.
And again, if you want to look at the chart before responding, you are free to do so.
A. Would you mind reading the question one more

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time, please?
(Record read.)
A. (Continuing) Are you going to ask me what I did, or was that your question?
Q. Yes, that was my question, sir. I want to know what you did.
Did you examine the patient, did you look at the strips, did you order any tests? I want to cover each and every thing you did for this patient at 7:30.
A. I examined the patient.
Q. All right, what did that entail?
A. I looked at her, I reviewed her blood pressure, temperature.
I do not know if I did the internal exam myself, or if Ms. McCaslin did that. But you know, these are the physical findings types of things.
I reviewed the fetal monitoring tracing up to that point.
Q. All right, let me ask you, Doctor:
When you say, you reviewed the fetal monitoring tracings, would you have gone back five or ten minutes and looked at them, or would you have gone back through the whole night and looked at them?

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A. I don't recall the extent of that review, sir.
Q. But in practical terms, what is your practice, what would you normally do?
A. I would have gone through all of them, you know, going over all that appeared to be pertinent at that time.
Q. Do you think you would have gone back at least a half an hour or an hour to look at the strips?
A. Oh, yes. Yes.
Q. And was there anything concerning or alarming about the strips? Let's start from 6:30, then, and go forward.
A. Can I look at the strips?
Q. Yes.
In fact, I am going to have you start at the strips at 6:30, and go forward, and tell me if you see anything that is concerning or alarming to you?
MR. GOLDWASSER: I will find it for you.
THE WITNESS: Okay.
MR. GOLDWASSER: You want to start at 6:30?
MR. BECKER: Right.

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In fact, why don't you mark that.
(Thereupon, Plaintiffs' Exhibit 2 (Izanec) was marked for identification.)
MR. GOLDWASSER: Give him the number.
A. It is 11711, is the sheet number, 11711.
Q. Let's look at 11711. What are your comments on the long term variability of that strip, if any?
A. They are decreased.
Q. What significance, if any, is there from decreased long term variability?
A. Well, that the baby may be stressed, that the baby may be going through a deep sleep pattern.
Q. Okay.
A. It is something which is, as we said before, "worrisome," something which you cannot just say, okay, fine, I will forget about this.
Q. All right.
On 11712, Doctor, I see a reference to you. It says, epidural redosed by Doctor --
A. This is Dr. Iarussi, he is the anesthesiologist.
MR. GOLDWASSER: So that is not Dr. Izanec.
Q. Excuse me, okay.
Any evidence of -- why don't you proceed and

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go forward from 11712, and tell me, for example, 11713, do you see any decels there?
A. No, sir, I don't.
Q. Okay.
Who is Doctor, is it Fasi?
A. Fabi, F-A-B-I.
Q. She is the house doctor?
A. Yes, sir.
Q. Is she trained in obstetrics?
A. Yes, she is.
Q. Go ahead, Doctor, just go forward with those strips and tell me when you see anything that --
MR. GOLDWASSER: That what, raises a concern?
Q. -- raises a concern.
A. In 11714, the contractions are coupling. There appears to be a lot of fetal movement during this time.
MR. GOLDWASSER: What is a concern? Do you understand the question?
THE WITNESS: Yes, yes.
A. (Continuing) And with that --
MR. GOLDWASSER: Go ahead.
A. -- there is a change in fetal heart rate. And it is unclear from this pattern whether we are

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seeing the development of a bradycardia, possibly some late decelerations, possibly some variable decelerations. That is unclear.
Q. 11715?
A. And then as the contractions started to space out again, this bradycardia, variability, late deceleration, variable deceleration, whatever, straightens out, and then --
Q. Do you see a late decel on 11715?
A. Sir, all of these decelerations are so variable that I would be inclined to call them variable.
Which one do you think is a late deceleration?
Q. I am just asking you, Doctor.
You don't see anything that clearly is a late, on 11715?
A. No, sir.
Q. Go ahead.
A. No, sir.
And then again, as these contractions are coming in a more reasonable fashion, the heart rate has returned.
Q. What is the baseline at that point?
A. I believe it is in the 160s.

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Q. Okay.
A. So now I am up to 11717.
Q. Okay.
A. Now we are at 11719, we talked about that. She is eight centimeters, so now we know where we are. Her temperature is as written there, baby still active, patterns very similar.
MR. GOLDWASSER: I just want to emphasize to you, he only wants to know that which is concerning.
A. (Continuing) Okay, so then that is that.
Q. I am sorry, could you repeat that answer again?
A. Oh, at 7:30, the pattern looks stable.
Now, do you want to go further?
Q. Well, you have indicated that what you did when you got there at 7:30 is you looked at the strips that had been generated prior to your arriving, correct?
A. Yes.
Q. And you did an examination. What else did you do for the patient at that time?
A. Okay, we ordered a CBC.
Q. And the reason?
A. Was to determine the mother's response to the

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temperature elevation which she has.
Q. Can you be more specific, what were you looking for in the CBC?
A. For signs of an elevation in the mother's white count which would signify infection.
Q. And was that ordered on a stat basis?
A. Yes.
Q. When did you have the results of that?
A. Those came back to the floor at about 9:30.
Q. Is that normally how long it takes at Marymount Hospital to do a stat CBC?
A. I don't know what the normal time would be, sir.
Q. Well, it seems to me, Doctor, that taking two hours for a stat CBC is kind of unusual. And I am asking you if that is routine for that hospital?
MR. GOLDWASSER: Answer only what you know. If you know the answer to that question, you may. I don't want to you guess.
A. To have the results sooner than two hours for stat is preferable.
MR. GOLDWASSER: That is not what he is asking.
Read the question back, please.

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(Record read.)
A. (Continuing) I don't know.
Q. Well, how long have you been practicing out of that hospital, how many years prior to this delivery had you been practicing at this hospital?
A. Seventeen.
Q. Seventeen?
A. Yes.
Q. Can you tell me, based on your experience with patients, and ordering a stat CBC, how long it normally takes to get that data back to you?
A. Thirty to forty-five minutes.
Q. All right, so you came at 7:30, you ordered a CBC, you did an examination, you looked at the strips, you went back at some period of time. What else did you do for the patient?
A. I discussed with Genny, with Ms. McCaslin, that it would be -- you know, that we were anticipating that the baby would be delivered within the next couple of hours, although -- pardon me -- that the baby would be delivered soon, I don't believe I ever gave a specific time, that the baby would be delivered soon, and that since she was making progress, that the baby's head was descending, that we would continue on planning for a

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vaginal delivery.
Q. And you left?
A. I went to surgery, yes.
Q. And if there were any new developments or change in the fetal heart patterns, you would have expected Nurse McCaslin to get ahold of you?
A. Yes.
Q. And if you were unavailable, then she would be getting ahold of your partner?
A. Right.
And in an urgent type of situation, where something needed to be done immediately, Dr. Fabi would be able to address that.
Q. So Nurse McCaslin had a number of options if there was a change in the picture between 7:30 and 9:30, correct?
A. Yes, if I could not come, yes.
Q. And those options were Dr. Fabi, yourself, or your partner?
A. Yes.
Q. And you next saw the patient at what time?
A. Sometime between 11:00 and 11:30. I do not recall the time.
Q. And was that simply to deliver the patient? I mean, were you called just to --

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A. No, no. I came up there to see how things were, to reassess the situation.
Q. And what did you find when you arrived at 11:00 or 11:30?
A. Well, that progress had been made, that the baby was close to delivering.
Q. And did you also go back and review the strips that were generated between the last time you had been there?
A. Yes.
Q. Let's look at them, from 7:30 on, and the same question, point out any areas of concern from 7:30 on?
A. The question is --
MR. GOLDWASSER: Matters of concern.
A. (Continuing) Matters of concern.
No. No, sir.
Q. No reason for concern in the strips that you looked at between 7:30 and approximately 11:00 o'clock; is that correct?
A. No matters of concern for fetal distress.
Q. Doctor, is there any reason why you didn't place an internal monitor on the patient at 7:30?
A. Yes.
Q. Tell me?

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A. Because the fetal monitoring pattern was very clean, there was no extraneous interference.
Q. When do you implement an internal monitor?
A. When I need to have -- when the external monitor tracing is unclear and I need to have a quality reading.
Q. Do you subscribe to the belief that an internal monitor generates a much more reliable indicator of short term variability than an external monitor?
A. No. I mean, not necessarily so.
Q. Do they have scalp pH devices at Marymount Hospital?
A. Yes.
Q. When do you utilize a scalp pH device?
A. When I am concerned about fetal distress.
Q. Can Nurse McCaslin, on her own, apply an internal monitor?
A. I don't know that, sir.
Q. Can Nurse McCaslin, on her own, obtain a scalp pH via a scalp device?
A. I don't know that.
Q. Have you ever trained her how to do that?
A. No, sir.
Q. Have you ever trained her how to put on an

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internal monitor?
A. No.
Q. If you found out that she put on an internal monitor without your consent, would you be upset with her?
A. I don't have an opinion on that at this time.
Q. All right.
You don't see any repetitive deceleration patterns in the second stage of labor?
A. I do.
Q. Oh, you do?
But it is not -- it doesn't rise to the level of concern that you would call fetal distress?
A. Right, yes.
Q. And what is the reason for that?
A. Well, because there is good return to the baseline, the baby is compensating with the stress of the contractions well.
Q. So you are not concerned about repetitive decels, as long as there is good return to the fetal heart rate baseline, correct?
A. That depends on the type of decel.
Q. Well, we are talking about late decels here.
A. I think we are talking about variable decels here.

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Q. Oh, you would call them variable decelerations?
A. Yes, sir.
Q. You would not call them late decelerations?
A. Looking at the big picture, I think that they are far more likely, far more probably variables than lates, looking at the big picture.
Q. What do you base that on, that they are more likely variables?
A. Well, the patterns.
Q. If you are teaching someone who has never studied fetal monitoring strips the difference between a variable and a late, what would you tell them?
A. Boy, that is a thirty minute answer. Do you want a class in that? I mean, could you be more specific? If you want me to give you the differences between both, I mean, I will do all that for you.
Q. I am just a lawyer, Doctor. But it is my understanding that a variable occurs -- the deceleration occurs at the same time of the contraction, and a late, what distinguishes a late from a variable, is that the deceleration occurs after the peak of the contraction. Am I close? Is

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that accurate?
A. I would define a late deceleration, the classic late, as beginning to -- as the fetal heart rate is beginning to decrease at the peak of the contraction, it goes down to its base, and then it returns to its baseline at least twenty seconds after the contraction is over.
Q. Okay.
A. The variable deceleration which you describe sounds very much to me like an "early deceleration," which is, as it were, the mirror image of the contraction as far as its pattern.
Q. Okay.
A. And then the variable deceleration can begin basically at any time, associated with the contraction, it can last for -- oh, boy -- a certain amount of time, I believe it is twenty to thirty seconds, at least, and it returns to the baseline then. And its timing is variable with the timing of the contraction, as opposed to the early and the late, okay? So variable contractions are variable, are variable.
And these contractions, I believe, are variable, in their start, and their stop, and their patterns.

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Q. What is your understanding as to the cause for a variable deceleration?
A. It is thought to be due to some kind of a temporary decrease in the blood flowing through the umbilical cord so that there is partial decrease in oxygenation, a time of stress for the baby. That is a variable.
Q. Did you have any contact with your partner during this labor?
A. I don't recall that.
Q. Would it be your practice or routine to make contact with your partner if you are managing one of his patients?
A. No.
Q. Did you have any other deliveries on the 27th before 11:30 a.m.?
A. No, sir.
Q. Do you know if your partner had any other deliveries on the 27th before 11:30 a.m.?
A. I don't know that.
Q. Now, this was an induction. Did you understand that?
A. Yes, sir.
Q. Did you first glean that information at 5:30 a.m. when you received a call from Nurse McCaslin,

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did you first learn that?
A. Boy, I don't remember that, sir.
Q. An induction because she was post-term?
A. Yes.
MR. GOLDWASSER: Post-date?
Q. Post-date, correct?
A. Yes.
Q. And is it routine in your office to induce when someone reaches 42 weeks?
A. That is the usual practice, yes.
Q. And the thinking behind that is that the placenta doesn't perform or function as well as it did at 38 or 40 weeks, correct?
A. Occasionally, that is the situation, yes.
Q. That is the general understanding in medicine as to why you induce at 42 weeks?
A. The general understanding is that at 42 weeks, there is an increased likelihood for the placenta to be -- or to begin its aging process, and to function less. But that occurred in maybe five percent of placentas at that time.
Q. Of course, if the placenta isn't working as efficiently as it once did or should, then there is an increased risk of oxygen deprivation to the baby during the labor process, correct?

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A. Yes, sir.
Q. Doctor, do you have an opinion as to why this child is brain damaged today?
MR. GOLDWASSER: You can only state it with probability. If you know, you may answer.
A. Because of the Group B Strep infection, or because of the finding that the placenta cultured out that bacteria, it is very possible that that bacteria could have caused the baby's brain damage.
Q. Through a meningitis?
A. For this particular baby, I don't know what the mechanism would be, sir.
Q. All right.
To your knowledge -- I know this wasn't your patient, but up until -- based on your conversations with your partner, did he anticipate a healthy baby up until the time of delivery?
A. Absolutely.
Q. And you did, as well?
A. Yes, sir.
Q. And Nurse McCaslin did, as well?
A. Yes, sir.
Q. Were the strips early on a good indicator that this was a healthy baby?

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A. Yes.
Q. If there is chorioamnionitis ongoing, do you know how that potentially reduces fetal oxygenation, do you have an understanding as to -- strike that.
Do you have an understanding whether chorioamnionitis creates a risk of compromise of oxygen exchange between the mother and the fetus?
A. I am not aware of that mechanism precisely, sir.
Q. You have not heard of that before? Strike that.
Do you know what the dangers -- back in May of '95, did you know whether there were any dangers to the fetus from chorioamnionitis?
A. Yes.
Q. And what did you understand, back in May of '95, those to be?
A. That the fetus, per se, that the baby itself could become infected with the bacteria, if bacteria would get into the baby's lungs causing a pneumonia.
Q. Okay.
A. It could also go into its GI tract. And you know, that the baby could actually die from the infection.
Q. If the record reflects that Dr. Fabi was

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rendering care in the afternoon of the 26th at approximately 3:55 p.m., can you tell me why that would be, why would she be rendering care rather than you or your partner?
MR. GOLDWASSER: That would be upon admission to the hospital.
A. Dr. Fabi is the house doctor, and it is her responsibility, when a woman comes to the labor floor, for her to do an admitting history and physical.
Q. Nurse Midwife McCaslin, did she have authority, back in May of '95, to order IV antibiotics, if she felt it was indicated?
MR. GOLDWASSER: Don't guess. If you know, answer. I don't want you speculating.
A. Well, she has the authority, yes.
Q. Doctor, the second stage of labor begins when the woman becomes fully dilated, correct?
A. Yes, sir.
Q. On a woman, what is the normal length of time for the second stage of labor, on a woman who is going through her first pregnancy?
MR. GOLDWASSER: Listen. What is the normal. He is not talking about this case.
THE WITNESS: Right, right.

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A. There is no normal.
I do not know what the average length of time is. I have forgotten that number.
Q. Is there a period of time when a woman reaches the second stage of labor, after a woman reaches the second stage of labor, when you grow concerned about some type of dysfunction in the delivery, descent and delivery?
A. After three hours.
Q. Do you recommend the administration of Demerol to a patient in the second stage of labor?
A. Depending on the situation, maybe, maybe not.
Q. In your review of this chart, did you note that this woman, Nicole McClain, was administered Demerol during the second stage of labor?
A. At 10:10, yes. Yes.
Q. Do you feel that was appropriate?
A. Yes, sir, I do.
Q. Isn't the administration of a narcotic during the second stage of labor risky because it increases the probability of the fetus being depressed at birth?
A. That is a dose related or a dose proportionate type of question, sir. So I can't answer that.

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Q. You have no problem with her administration of Demerol to this patient at 10:00 o'clock in the morning, correct?
A. In this situation, no, sir.
Q. Speaking generally, would you agree that Pitocin is contraindicated in the presence of fetal distress?
A. No.
Wait, pardon me, pardon me. In the presence of fetal distress? I am sorry.
MR. GOLDWASSER: Do you want that question read back to you again?
THE WITNESS: Sure.
MR. GOLDWASSER: Read it back.
Do you need a break, Doctor?
THE WITNESS: Oh, no, no.
MR. GOLDWASSER: Read it back, Ivy.
Listen carefully.
(Record read.)
A. (Continuing) Yes, yes. I do agree with that.
Q. Upon seeing this depressed newborn, what did you do?
MR. GOLDWASSER: You are talking about what time now? When he first saw the baby?
Q. (Continuing) Weren't you present at the time

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of delivery?
A. I don't recall that, sir.
Q. Does the chart reflect whether you were present at the time of delivery?
A. Not clearly, no.
Q. Under Number 6, Intrapartum Delivery Sheet, your name is on there; is that correct?
A. Yes.
Q. What does that mean? What does that signify, if your signature is on that section box entitled, delivery personnel, what does that mean?
A. I was countersigning Ms. McCaslin's name.
Q. Why?
A. That is a medical records requirement.
Q. So that does not mean that you were present at the time of delivery?
A. Not necessarily.
Q. When was it and where were you located when you first heard about this depressed newborn?
A. I was right outside the room, sitting at the nurses station on the labor floor.
Q. Did someone run out and grab you, or yell for you?
A. Boy, that, you know, I just don't recall.
Q. Did you see any evidence of tachycardia in

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this child in the last few hours of labor?
(Thereupon, a discussion was had off the record.)
(Short recess had.)
(Thereupon, Plaintiffs' Exhibits 3, 4 and 5 (Izanec) were marked for identification.)
A. During the 11:00 o'clock hour, there were intermittent times of the fetal heart rate being in the 170s.
Q. Would you have expected the midwife to have brought that to your attention during the 11:00 o'clock hour?
A. No.
Q. Any other time?
A. There was no consistent tachycardia that I can see here.
Q. And when you are using the word, tachycardia, are you talking above 180, or are you talking above 160?
A. I am talking about the 160. So 160, 164. Like I am counting that as being 160.
Q. Speaking generally about the administration of Demerol in the second stage, would you agree with me that if there was fetal distress present, Demerol during the second stage would be contraindicated?

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A. Considerations of dosing are very important here. And if we agree on that, then I would agree with you that you don't want to give Demerol in the second stage when there is fetal distress.
Q. I didn't understand your answer, Doctor.
Are you saying over a certain level --
A. Amount of Demerol.
Q. What amount is permissible, and what amount of Demerol in the presence of fetal distress would be contraindicated?
A. 25 milligrams intravenously or more.
Q. Doctor, if there are repetitive late decels, how long do you feel you should permit a patient to proceed in labor before prudence demands that you intervene and terminate labor?
A. I do not have an opinion on the specific number of late decels.
Q. Are we talking ten minutes, are we talking twenty minutes, are we talking thirty minutes, are we talking an hour?
MR. GOLDWASSER: This is persistent late decels?
MR. BECKER: Right.
MR. GOLDWASSER: In the presence of persistent late decels, is his question.

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You may answer.
A. I would need to know the other aspects of the fetal heart rate pattern, how close the person is to giving birth vaginally. I don't have an opinion on the precise time frame.
Q. If a patient is experiencing stress, as compared to fetal distress, is there a period of time where it accumulates and would become, in your mind, fetal distress?
A. Yes.
Q. Longstanding stress?
A. Yes.
Q. What period of time? Are we talking half an hour, are we talking an hour, are we talking two hours?
A. I couldn't answer that question, sir, on a time basis. I don't really look at time. I look at what the baby is doing.
Q. But you acknowledge that even with your definition of stress, if it is ongoing and longstanding, it can convert into fetal distress --
A. Yes.
Q. -- just based on the length of time it has been on board or present?
A. Time is really not the variable there, sir.

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It is the baby's resilience, it is the placenta, it is how the mother is doing. It is those things. And time is not the thing. Time is really not the variable.
Q. Do you have any problems with the administration of Pitocin during this labor?
A. During this labor?
Q. Yes.
A. Generally speaking, no.
Q. In retrospect, do you feel that Damien would have benefited from intrapartum antibiotics to the mother?
MR. GOLDWASSER: I am going to object. I want to object. Retrospect is easy in every respect.
Go ahead, with my objection noted that it is a fundamentally unfair question. You may answer.
A. I just don't know. I don't know.
Q. You are a member of ACOG?
A. (Witness nods).
Q. Would you agree that the ACOG bulletins that were in existence at the time that you rendered care to this patient set forth the minimum standard of care for a prudent obstetrician?

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A. No. They usually don't set up a standard of care, actually. No.
Q. You don't think that the recommendations from the American College would reflect a minimum standard of care of what an obstetrician, a prudent obstetrician, should do under the circumstances as described in a particular bulletin?
A. They are recommendations, they are suggestions, they are excellent food for thought. But unless they state specifically, this is what should be done -- and the ACOG committee opinions do that now, the approach to Group B Strep prophylaxis is crystal clear --
Q. You are talking about currently?
A. Currently, right, right. And that, I think, is an excellent example. Because you know, that -- although they never say, standard of care, boy, that is as close as we ever get.
Q. Doctor -- excuse me, are you done?
A. Yes.
Q. I am going to hand you three more exhibits, which I think encompass everything in the chart that you generated, and I am going to go into these three documents. And these documents are marked 3, 4 and 5.

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But before I go into the detail of these, what I would like you to do, Doctor, is take a look at the documents, and take a look at the chart, and tell me if there is anything I have missed, that you have generated, that is not reflected in these documents.
That was a long question. Do you understand it?
A. Yes, sir.
Q. Okay.
A. Yes, these are my documents.
Well, these two, these summaries, were both -- are the same document. They were dictated by Ms. McCaslin. These are my corrections when I countersigned it.
This is --
Q. You are referring to Number 3?
A. Yes, apparently, right, Number 3 --
Q. Which is a discharge summary?
A. -- is the discharge summary, the same as Number 4, but this is before my corrections. And my recall is that I made these corrections in the medical record when I was signing off my charts. And I did not date when I had done that.
Q. All right, so 3 and 4 essentially are the

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same?
A. Are the same, yes.
Q. Would you pull your copy of -- your corrected copy, do you have that at hand?
A. I don't know if I do.
MR. GOLDWASSER: First of all, this is my record of the chart, my copy.
In fact, I don't have the uncorrected copy.
MR. BECKER: Well, Gary, I am going to leave these exhibits with Ivy, and she can make copies and attach them to the deposition.
MR. GOLDWASSER: Again, this is my record, so it is not his.
BY MR. BECKER:
Q. I am just going to ask you a few questions off of the discharge summary, Doctor, okay?
A. Yes, sir.
Q. Well, are you saying that this was dictated by Nurse McCaslin, and not by you?
A. Yes, sir.
Q. But you cosigned it, or countersigned it, meaning you agree with it as corrected?
A. Yes, sir.

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THE WITNESS: May I take a break?
MR. GOLDWASSER: Sure.
(Short recess had.)
BY MR. BECKER:
Q. Let's go on to Exhibit 5, Doctor, which is your handwritten notes. And what I would like you to do --
MR. GOLDWASSER: It is under progress notes, the next page.
Q. -- is read them to me verbatim, and when you come to an abbreviation, do not utilize the abbreviation, tell me what you mean by it.
A. Yes, sir.
Agree with -- delivery comment, this is May the 28th at 10:40, delivery comment.
Agree with note from May 26, 27 by McCaslin. Need to induce 42 week intrauterine pregnancy (dates by ultrasound). Fortunately average size baby by estimated fetal weight and amniotic fluid clear.
Gentle induction, modest amounts of oxytocin. Labor length about twenty hours; seventeen hours of second stage --
MR. GOLDWASSER: First stage.
A. (Continuing) Pardon me, seventeen hours of first stage, three hours of second stage (and third

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stage).
Initially fetal heart rate baseline 130s, no decelerations, good variability.
Q. Excuse me, let me stop you there.
This form, this delivery comment, is this kind of a recap of the whole labor by you?
A. Yes.
Q. And it was done at 10:40 in the morning, the day after delivery?
A. Yes, sir.
Q. All right, go ahead.
A. At 0520, May 27th, temperature 100.9, cervix five to six -- and then that is centimeters, if you agree that is an abbreviation -- fetal heart rate baseline 140s.
At 0631, cervix is seven to eight centimeters, baseline 150s, still no decelerations.
At 0655, four decels in five contractions. Variable decelerations. Baseline increased after these to 160s, 170. In parentheses, then no more decels. I believe that is a closed parentheses after that.
At 0830, complete, baseline 150s, 160s, no decels -- no decelerations.
At 0915, early decelerations to 140s. Return

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to 160s with compensatory accelerations to 170; deeper early decelerations to 120s. That is at 0930.
The next sentence, if you will, baseline then 150s, 160s; at 0948, decels look variable -- pardon me -- decelerations look variable to 90s, 100s; baseline 150s, 160s; then begin compensatory tachycardia to 170s, 180s, baseline still 150s, 160s.
Q. When did the compensatory tachycardia kick in?
A. According to -- well, it occurred after 9:48, sir, and prior to delivery.
Q. So what you are doing here, Doctor, a day later, you are taking the chart and the strips, and you are kind of summarizing your interpretation of what was occurring while these strips were being generated, correct?
A. Yes, yes.
Q. So when you say, compensatory tachycardia, what you mean by the word, compensatory, is that the baby's heart is beating faster because not enough oxygen is getting to the baby's brain?
A. Because the baby was being stressed during the contractions.

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Q. And when the baby becomes stressed, the baby's brain sends a signal to the heart to beat faster to send more blood up so that we can meet our oxygen demand; isn't that your understanding of the concept of compensatory tachycardia?
A. Yes, yes. But that is not just for the brain, it is for the baby's body.
Q. Okay.
Continue on.
A. Delivery after three hours, cord loosely draped over shoulder, no meconium ever. Newborn heart rate 150s. Immediate resuscitation. Not breathing spontaneously.
Q. Okay.
A. Question cause of hypoxia. Question infection. Born six hours after temperature 100.4, (went to 101.4). Checking placenta. Question cord.
Why no meconium - classic sign of hypoxia. And then I signed my name.
Q. Is there any question in your mind, Doctor, that this child was severely acidotic at birth?
A. No, no.
Q. And is there any question in your mind, Doctor, that the reason the child was severely acidotic at birth was due to oxygen deprivation

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during the course of the labor?
A. That, I just don't know.
Q. Doctor, if the membranes, although clear, were the color yellow, at the time the amniotic fluid was yellow, what if any significance could you draw from that?
If the color of the amniotic fluid upon rupture is something other than clear, let's assume it is clear yellow or clear orange, what is the significance of that?
A. It is never clear yellow or clear orange.
Q. So if it is yellow, it is cloudy?
A. It would be kind of a milky yellow, you know, if it is yellow.
Q. What would a milky yellow signify?
A. Pus, I would think.
Q. Doctor, you made a lot of comment or emphasis on an absence of meconium. Do you feel an absence of meconium eliminates hypoxia as a cause of depression?
A. Would you mind asking me that again?
Q. Yes, let me restate the question. It was a poor question.
Do you think that the presence of meconium is always an indicator of fetal distress, of fetal

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stress or distress?
A. No.
Q. Isn't it true, Doctor, that twenty to twenty-five percent of all babies born pass their meconium prior to delivery?
A. I don't know what that percentage is.
Q. Is there something you have learned or read which tells you that unless meconium is seen, that there cannot be an hypoxic process going on?
A. It is my understanding that almost always, 99 percent of the time, 99.9 percent of the time, when there is hypoxia, there will be meconium.
MR. BECKER: Let's take a short break. I think we are done.
MR. GOLDWASSER: Sure.
Are you almost done?
MR. BECKER: Yes.
BY MR. BECKER:
Q. Doctor, the fact that this baby's blood cultures were negative, does that have any significance towards your opinion that maybe beta strep was a player in this child's injury?
A. I did not realize what the baby's blood cultures were.
Q. Are you aware of a patient pamphlet that has

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been put out by ACOG that says that if a patient has a temperature elevation in labor, that the patient should be offered antibiotics?
A. I am not aware of that.
MR. GOLDWASSER: Just for my sake, the second last question he asked about the baby, read that back.
(Record read.)
BY MR. BECKER:
Q. In looking back at these strips, Doctor, is there any time that you felt that you should have been contacted by Nurse McCaslin, that you were not?
A. No.
Q. Can we agree, Doctor, that at 5:30, this case became a joint management case between you and Nurse McCaslin?
A. Yes.
Q. And it continued that way up until the time of delivery?
A. Yes.
Q. It is your opinion, Doctor, that the fetal monitoring strips were reassuring throughout the labor? Strike that.
Is it your opinion, Doctor, from the time you were contacted at 5:30 until the time of delivery,

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that they were, in essence, reassuring?
A. Yes.
Q. Do you feel that the polyhydramnios is irrelevant to any potential cause of damage to this child?
A. Yes.
Q. You are not critical of any of the hospital nurses, are you?
A. No, I am not, sir.
Q. You appreciate, Doctor, that when a midwife is present and managing a labor, that the obstetrical nurses would have a tendency to defer to the midwife?
A. I am not aware of that, sir.
MR. BECKER: Thank you, Doctor, for your time.
THE WITNESS: Thank you.
MR. GOLDWASSER: I will have the doctor read it.
- - -
(DEPOSITION CONCLUDED)
- - -

James J. Izanec, M.D.

CERTIFICATE

State of Ohio, } ss:
County of Cuyahoga. }

I, Ivy J. Gantverg, Registered Professional Reporter and Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the above-named JAMES J. IZANEC, M.D., was by me first duly sworn to testify to the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the deposition as above set forth was reduced to writing by me, by means of stenotype, and was later transcribed into typewriting under my direction by computer-aided transcription; that I am not a relative or attorney of either party or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office at Cleveland, Ohio, this 17th day of February, 1997.

Ivy J. Gantverg, Notary Public
in and for the State of Ohio.
Registered Professional Reporter.

My commission expires September 13, 1998.

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