IN THE COURT OF COMMON PLEAS
RICHLAND COUNTY, OHIO

LISA M. YATES, ADMIN. FOR THE ESTATE OF DYLON JOHN KING, DECEASED, ETC. : CASE NO. 01-389D
Plaintiff : Judge DeWeese
v. :
MEDCENTRAL HEALTH SYSTEM, et al. :
Defendants : Pages 1 - 83

Deposition of Marc Lowen, M.D.
Linthicum, Maryland
Thursday, December 19, 2002

Reported by: Linda H. Cole, Notary Public

December 19, 2002
10:02 a.m.

Deposition of Marc Lowen, M.D. held at:

Sheraton International Hotel
7032 Elm Road, BWI Airport
Baltimore, Maryland 21240

Pursuant to notice, before Linda H. Cole, a Notary Public of the State of Maryland.

APPEARANCES:

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On behalf of the Plaintiff

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On behalf of the Defendant, Women's Care of Mansfield, Inc.

I N D E X

E X H I B I T S
(Exhibits attached.)

Thereupon,

MARC LOWEN, M.D.

a witness herein, called for oral examination in the matter pending, being first duly sworn to tell the truth, the whole truth and nothing but the truth, testified as follows.

(Exhibit Nos. 1 and 2 premarked.)

EXAMINATION

BY MR. RANKIN:

Q Good morning, Dr. Lowen. My name is Greg Rankin, and we just met a few moments ago. Let's start by my handing you what we have marked as Lowen Exhibit No. 1, which is your C.V. Is that relatively up-to-date and current?

A Yes, that's current.

Q Let me ask you about a couple of publications you have listed in your C.V. I note that there are several that may pertain to the issues in this case. The first one that I've highlighted there is the Value of Fetal Monitoring. What is that?

A That was a letter to the editor commenting

on a case that questioned whether or not fetal monitoring was important, and my letter said that I thought it was important.

Q This was written when?

A In 1977. A long time ago.

Q Now is that different from the publication immediately above it on your C.V., where you indicate a letter to the editor regarding maternal morbidity?

A That's a different letter; that's 1976. And that was also a comment regarding a maternal death case presentation, and I made some comments in a letter to the editor.

Q I note that whereas in that publication in the matter pertaining to the value of fetal monitoring, you don't designate that as a letter to the editor?

A I'm pretty sure that's a letter to the editor.

Q And then the next publication that may bear relevance to the issues in this case is the role of midwives in the New England Journal of Medicine. What

is that?

A That is a discussion -- I think that's also a letter to the editor -- and that was regarding nurse-midwives being trained at a program that also was training obstetrical residents. The letter dealt with whether or not we were diluting the patient pool for the resident education by also running a nurse-midwife training program at an institution that was described in an article that I was commenting about.

Q What was your position in that regard?

A My position in that particular program was that they should concentrate on educating residents and not continue with their nurse-midwife program.

Q Philosophically what is your current attitude towards the role of midwives?

A I think that they are a valuable asset to obstetrical practices.

Q Does your practice involve the use of midwives?

A Yes.

Q How much?

A We have one nurse-midwife in our practice.

Q Historically has that --

A She's been the only one. We've had her for probably 12 to 14 years.

Q How big is your group?

A The group is four of us -- five, including the nurse-midwife. Two practicing OBs and three practicing gynecology, currently.

Q And approximately, how many babies per year does the group deliver?

A About 230.

Q And over the last five years, has that number stayed the same?

A No. It's increased.

Q Five years ago, how many were you delivering?

A Five years ago, we were probably delivering 180.

Q And what percentage of those deliveries involved midwives?

A I don't understand the question.
Q I'm trying to gain an understanding as to how extensively involved the nurse-midwife is in these deliveries and under what circumstances she would assist or participate?
A Probably 50 percent in some fashion. Whether she did 50 percent of the deliveries is probably not correct, but she certainly saw all the OB patients in the office and took night call.
Q Could you give me a range and estimate the approximate number of deliveries and the circumstances under which she's assisted in active labor?
A She takes regular night call. And if it's her night and the patient goes into labor, she's on call that night.
Q How often per week is she on call?
A Probably three times a week.
Q Again, with respect to that publication, the role of midwives, that's not designated on your C.V. as a letter to the editor but you're fairly certain that is a letter to the editor?

A I'm fairly certain it's not an original article. It's a letter commenting about an article.
Q Was there anything in these publications or presentations that you've listed on your C.V. -- would any of the other matters listed there have any particular relevance to the issues in this case?
A No.
Q Describe your personal practice for me. How do you spend your professional time?
A Currently?
Q Yes.
A Currently, my time is divided 50 percent as an employee of Sinai Hospital as the program director of the obstetrical residency program. The other 50 percent is spent in private practice at a site not on the Hospital campus.
Q Is that the group of four physicians and midwife?
A Correct.
Q What is that group called?
A It's called Village OB-GYN.

Q And within that private practice, how do you spend your time, obstetrics or gynecology or both?
A Gynecology.
Q Exclusively?
A Exclusively.
Q Has it always been true that your private practice has been devoted to the practice of gynecology?
A No.
Q When did that come about?
A 1998 was the last time I did obstetrics in private practice.
Q When did you last deliver a baby in private practice?
A In 1998.
Q Why did you leave or change the focus of your practice from obstetrics to gynecology?
A First of all, I thought it was time in my life to do that, and I had the opportunity to be the residents' director at Sinai.
Q Is that when you took that position in 1998?

A That's when I took the position, yes. It was probably '97. I overlapped for about a year. It was probably '97 that I took the position, and in '98 I stopped doing obstetrics. And the second reason was it wasn't economically feasible for all the members of the practice to maintain OB privileges because of the malpractice premium.
Q Up until 1998, describe your private practice.
A From 1973, when I joined the current private practice until 1998, I was a full participant in terms of the obstetrics and gynecology and office practice, and I always did some teaching and residency involvement at the hospital. Certainly since 1992, I was partially employed at the Hospital.
Q I'm sorry. What year was that?
A '92.
Q Describe your responsibilities as the program director in obstetrics.
A The program director is an established position that has sort of pages of requirements to it.

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In essence, the program director is responsible for the educational piece of the residency program, along with chairman of the department, whose duties extend to many, many, other things. But the program director's duties are pretty much responsible to the residency program, meeting the requirements that the various organizations set up to have it approved, the residency program.

Q Are these administrative responsibilities, or do you get actively involved in the classroom or clinical?

A I get actively involved in the classroom, and I get actively involved in the clinic. I do not take in-house call anymore.

Q Describe what your typical role in a clinical setting would be.

A Preceptor in an OB-GYN clinic. I would go to the clinic for three hours, the residents would present all the cases that they see to me, we would discuss them and have a plan of action for the next visit.

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Q And when you say you go for three hours, how many day a week?

A That's only a piece. That's not on a weekly basis. I do that so I can stay in touch clinically with the residents besides all the administrative work that I do for them.

Q How often do you do that in an average week or month?

A Twice a month. But it's probably less than that if you average it over a year, probably more like once a month. I fit into a regular clinic rotation schedule only to help out with vacations and things like that. Our requirements are not to man an ambulatory clinic.

Q Is the bulk of your responsibility in that setting as program director administrative in nature?

A I would say 75 percent is administrative and 25 percent is teaching.

Q Other than your private practice and your position as program director, do you devote any other professional time to any other aspect of the practice

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like research, medical-legal consulting, things like that?

A Well, I'm here this morning. But other than that I also for the Hospital run a midlife health unit, so I lecture in the community for the lay public on issues relating to midlife and menopause.

Q How frequently do you do that?

A Six times a year.

Q How much of your time do you spend engaged in medical-legal consulting?

A Minimal.

Q In the last five years, how many cases have you reviewed?

A Fifteen. It would be an estimate. I don't review more than three a year.

Q And that's been true -- let me ask it this way. When did you first begin performing consulting work?

A I did it in a different realm. When I first got involved in looking at medical -- well, I wouldn't call it medical malpractice -- I would call it

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aberrant medical behavior through the Maryland OB-GYN Society where I was involved with looking over practices that physicians had been under question for whatever activities. So we would oftentimes do a practice review and an on-site visit to a doctor's office looking for their style of practice and what was going on. I think probably after that, I was approached.

Q When you did that, it was under the auspices of the Maryland Medical Association?

A Maryland OB-GYN Society. It was under MedChi of Maryland at that time. Are familiar with MedChi? It's called the Medical Chirurgical Society, and that is the governing body of the State of Maryland. They would call the Maryland OB-GYN Society and say we have an obstetrical or gynecological practice, and could you send us somebody that could go look at a practice and write a report, and then look at it again maybe in six months and see what people have done.

Q Over what time frame?

A Ten years.
Q '70s or '80s?
A Yes. More between '80 and '90.
Q And then as a result of or subsequent to that, you started to review cases involving medical malpractice?
A Yes.
Q So, again this is an approximation, but sometime in the late '80s or early '90s you first reviewed medical malpractice claims on behalf of either patients or physicians?
A Correct. It would probably by the early '90s.
Q What percentage of the cases that you looked at were review on behalf of the patient and what percentage on behalf of the physician?
A About 80 percent on behalf of the physician and 20 percent on behalf of the plaintiff.
Q Are you affiliated with any medical expert consulting services?
A No.

Q Do you advertise?
A Absolutely not.
Q How did you happen to be selected to become involved in this particular case?
A I'm pretty sure that I responded to a flyer from Donna Taylor-Kolis' office.
Q Do you know when you received the flyer?
A I would have to say that it would have to be '99 or 2000. May '99, but I'm not exactly sure.
Q What was the nature of the flyer as you call it?
A I actually had to be reminded of that, because I didn't remember initially how we met. But I think it asked about -- I think that the flyer got to me because I was a program director of a residency program, and I guess the question was asked would you be willing to read malpractice cases. And I called and responded that I would, but certainly on a limited basis. I don't have enough time to do it on more than a limited time basis.
Q And when were you asked specifically to become involved in this case and review the records?
A I don't remember the month, but I'm pretty sure it was 2000. It probably was the end of '99 or the beginning of 2000, because my letter to Donna Taylor-Kolis was August 28th, 2000 so I must have had the case prior to that.
Q By the way, what percentage of your income is derived from performing medical-legal consulting?
A Based on the numbers that I told you, minimally.
Q Less than five percent, 10 percent? If you know.
A Less than five percent.
Q You were asked to bring certain documents here with you today, and let me go through the list. All the materials and records that you reviewed to form the basis of your opinion which you intend to render at trial?
A Correct. There is one document that I do not have with me. Donna had sent it out to me I'm embarrassed to say probably twice, and it's still not

with me. It's a document dealing with -- it has to do with the nurse-midwife agreement between -- I have one agreement, but this isn't the exact document that I was looking for. There's a document that outlines the nurse-midwife's responsibilities in a bunch of different situations at --
Q MedCentral?
A Right. And I've seen that document, and I will make a reference to it on one question if you ask me the question, but I don't have it with me. I'm sorry.
Q Is this it possibly, Certified Nurse-Midwife Guidelines?
A Yes.
Q You've seen it but you don't have it, but what you do have is a Standard of Care Agreement?
A Correct.
Q Is that dated, since we're dealing with people who aren't present here?
A It's on the back.
Q The one that's signed by Susan Beach-Morgan

and the physicians at Mansfield Obstetrics & Gynecology Associates, Inc., is dated September 8th, 1999. Correct?

A Correct.

Q It's a six-page document?

A Correct.

Q You have a deposition transcript of Ms. Susan Smith taken 12/3/02, the report of Dr. Elliott dated September 3, 2002, the report of Joyce Roberts dated September 12th, 2002.

A And a copy of my letter that I originally wrote to them.

Q There's a cover letter from Ms. Donna Taylor-Kolis, and just let me identify it. There's a cover letter from Donna Taylor-Kolis dated September 23rd, 2002, enclosing the reports of Ms. Roberts and Dr. Elliott. And I will just reach across here for Dr. Lowen's handwritten notes on the front of one page, and then there's a letter to Donna dated August 28th, 2000, a three-page letter, regarding his review of some of the materials in connection with this case.

A That was before I -- I didn't have -- there are new materials that I've gotten since then.

Q Correct me if I'm wrong, but this letter that is dated August 28th, 2000, I assume reflects your preliminary opinions that you formed after reviewing the medical records, and then after you wrote this letter you received deposition transcript reports and other materials?

A Correct.

Q Those materials have not caused you to change the opinions that are contained in the August 28th, 2000 letter?

A No.

Q I have everything else, but I would like to mark -- I don't know if they have copying capabilities here at the hotel -- but can I put a sticker on this for now and we'll worry about copies later?

A You can have this.

Q The typed letter?

A Right. And this, I just need to refer to but you can have that when I'm finished.

(Exhibit Nos. 3 and 4 marked.)

Q Other than this case, have you reviewed any other cases for Donna or members of her firm?

A I think one other, but I hope you're not going to ask me to tell you about it because I don't recall. But if Donna is there she might recall, but I don't recall.

Q I assume that was on behalf of a patient, a plaintiff suing a physician?

A That I think was on a plaintiff again, yes.

Q Have you reviewed any other cases for any attorneys other than Donna in Ohio?

A I don't think so.

Q I assume you don't know Donna?

A I have in Florida -- know her?

Q Yes. Other than through reviewing cases for her, any member of her firm or family member or friend or associate that you had contact with?

A None at all.

Q From her firm?

A Her firm? I had contact with a gentleman by

the name of Chris.

THE WITNESS: Right, Donna? Chris is the one who talks to me?

MS. TAYLOR-KOLIS: He's my paralegal.

Q You mentioned that you have reviewed -- other than these cases, assuming there are two of them in Ohio, you have reviewed cases in Florida?

A Florida.

Q Any other states?

A Florida sticks out, and I don't recall. I have reviewed in the State of Maryland, yes.

Q Do you know approximately how many cases that you've reviewed have involved claims of medical malpractice here in Maryland?

A Five.

Q How about in Florida?

A Two -- let me correct that. Malpractice would mean I would be reading for the plaintiff?

Q Well, either.

A In Florida, I read for the hospital. It was to look at a group practice that had some

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obstetrical -- the practice was having too many bad outcomes obstetrically, and they asked me to review it to see if I could think of anything for their practice to help them. My recommendations dealt with they needed to increase their employment. They needed to get a hospitalist. Ultimately, the bottom line after reviewing all of that was that the hospital provided a hospitalist for this group, and it helped them decrease their -- so that was the Florida one. And I've read another case for the same law firm. Also, that was for a physician, and I think that was a malpractice case.

Q Other than Florida, Ohio, and Maryland, have you reviewed cases for any party in any other states?

A Not that I recall. But I'm sure that's not accurate, because 15 cases I don't remember. Fifteen or 20 cases, I don't remember where they are all from so I'm sure that's not accurate.

Q On how many occasions have you testified in court in a malpractice claim?

A Never.

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Q On how many occasions have you given depositions?

A Twice.

Q Is this your second deposition?

A Second.

Q Have you been asked to testify as a witness when this case proceeds to trial in Mansfield, Ohio, in January of next year?

A Yes, I have been asked.

Q Have you agreed to do that?

A Yes.

Q What do you charge for your professional time?

A The only figure I can give you is the reading time -- honestly, we have never discussed this time or testifying time -- so reading time is $250 an hour.

Q And are you going to think about the other value you'll attach to the other time?

A Sure. Let me see if I can raise that percentage from under five to five and a quarter.

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MR. RANKIN: Donna, I think our interests, yours and mine, are probably aligned in this case for the purposes of the deposition and this trial testimony, so I'll try to work out the best deal I can before I leave here.

MS. TAYLOR-KOLIS: Great. I appreciate that.

THE WITNESS: I'm going to become educated now.

Q Back to the items requested in the notice of deposition. Did you review any medical literature in the course of formulating your opinions in this case?

A No.

Q Are there any texts that you consider authoritative or particularly useful in the area of obstetrics, and in particular labor and delivery of babies?

A Probably the gold standard is a textbook called Williams Obstetrical Gynecological textbook, but I didn't read it particularly for this particular case.

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Q Any others that are used commonly by your residents in your program besides Williams?

A Williams is the textbook that we provided for them, so that's what we use for obstetrics.

Q And I take it that you didn't review any ACOG bulletins or guidelines in formulating your opinions in this case?

A No.

Q And the working notes are contained on that one sheet of paper?

A Correct. I tried to recover any notes that I had for the letter, and I couldn't find any notes that I had for the letter. So this is --

Q This is the earliest letter?

A Right, that's 2000. But this is current and prepared for today.

Q How much time have you devoted to review of materials in connection with this case up until today's deposition?

A I think I have billed Donna for close to six hours.

THE WITNESS: But Donna, you correct me if I'm wrong, because I think that's what I've billed you for. I haven't billed you for today or any preparation for today. Is that correct?

MS. TAYLOR-KOLIS: I think that's accurate.

Q You don't have that billing statement with you today, do you?

A No.

Q The final thing in the duces tecum list were any records that would reflect or identify any other cases in which you served as an expert witness. Do you maintain such a list? Some experts do to comply with a federal court ruling. It's called a Rule 26 list, if that means anything to you.

A It does not. The only thing I would ever have with those cases would be I store some of them in these kinds of binders in a basement, but that's all I have.

Q With respect to the materials that are in your binder and the deposition transcript, have you

written on any of those pages or made any notes, Post-it notes, on any of those?

A I folded back a page here, referring to this document.

MR. RANKIN: Just for the record, I'll read in that in Susan Smith's deposition transcript you folded back page 56.

Q Why did you do that?

A I'll have to read it, but I thought it was a good chronological summary of the day. I did two other things here. These are my tabs that I put on the fetal monitor strips. I have two tabs.

Q I don't need to see them right this minute, but those are the only two tabs?

A And I did fold back two pages or three pages.

Q Let's just identify those pages for the record, and you can use the Bates stamp on the bottom.

A 42, 75, 105, that's it.

Q 42, 75, and 105 are the pages that were folded back. What pages have you placed Post-it notes

on?

A 36 and 2.

Q Prior to this case --

A I'm sorry. There's a third. That's 107.

Q A Post-it note?

A Yes.

Q Prior to this case, did you know or were you aware of Susan Smith, the nurse-midwife?

A No.

Q Do you know or are you aware of, outside of this case, Joyce Roberts?

A No.

Q Dr. John Elliott?

A No.

Q Do you have any personal or professional connection with the State of Ohio?

A No.

Q Have you ever been there?

A Sure, Cincinnati.

Q That's in Ohio.

A And Cleveland. I have some friends in

Cleveland and family in Cincinnati.

Q And you are not, nor have you ever been, licensed to practice medicine there?

A No. Practice medicine in Ohio, right? You were referring to Ohio?

Q Yes. What did I say?

A I just wanted to make sure that I didn't answer that I'm not licensed to practice medicine anywhere in America.

Q You are licensed to practice medicine?

A Yes, absolutely.

Q Your license is in good standing?

A Yes.

Q You've never had your license or privileges revoked or suspended for any reason?

A No.

Q Directing your attention, Dr. Lowen, to Exhibit No. 2, which is your letter of August 26th, 2002. Am I correct that this letter basically summarizes all the opinions that you've formulated in this case following your review of the medical

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records, and the deposition transcript of Susan Smith, the reports of Joyce Roberts, Dr. Elliott, and the standard of care agreement, and nurse-midwife guidelines?

A No. It only reflects -- as you mentioned before -- it was the initial perusal of the material that I had. I never had at that time the standard of care agreements with MedCentral, and I never had --

Q Before you go on, I was asking about this more recent letter. One is dated August 26th, 2002, and the earlier one was August 28th of 2000.

A Okay.

Q I was going to the more recent letter.

A Just give me a minute to read it.

(Witness reading.)

A Restate the question.

Q That was that long-winded question. Let me rephrase it a little bit. Does this letter of August 26th, 2002, which we have marked as Exhibit No. 2, reflect your current opinions after you have reviewed all the materials before us today?

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A Correct.

Q In this August 26th letter, you make reference to a letter of July 8th. Do you know where that letter is or what it contains?

A I think this is the letter. I don't think there was -- I am almost 100 percent sure that those are the only two letters that I sent.

Q Do you think there was any event on July 8th or any memorandum?

A I think that has to do with it. I think that was in a word processing program, and I think it automatically dated that. I don't think there's another correspondence, not to my recollection.

Q Will you check, and if something does surface you'll provide that to Ms. Taylor-Kolis?

A Absolutely.

Q Directing your attention to the third paragraph of Exhibit No. 2, you stated there that -- and I'm paraphrasing to some extent -- Ms. Yates was not an uncomplicated obstetrical patient and that her prenatal course was complicated by the fact that she

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missed numerous appointments during the prenatal phase of her pregnancy. Do you remember how many prenatal visits she missed?

A Five, I think.

Q Do you know how many appointments she made?

A I think she made eight to nine, so that would be the usual 13 or 14 that we see in a regular pregnancy.

Q Based on what you saw in the medical records that were contained in the chart regarding the appointments that she did in fact make, was there anything about her presentation at that time that made her a complicated obstetrical patient?

A She was complicated in the sense that she was a previous cesarean section who wanted to try a vaginal delivery, and I think a tubal ligation. I remember reading that somewhere. But she wanted a VBAC, vaginal birth after cesarean section. And since that is something that practices are encouraging to reduce the cesarean section rate in the country, that's something that she, I gathered, was offered and

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planned to have.

Q Any other complications that you saw before she appeared for induction on December 1, 1999?

A She was anemic. I think she had mild anemia. She missed an alpha fetoprotein screen at 18 weeks, and I think she missed that just because her timing was -- the appointment she missed, that was the time when they would have drawn an alpha fetoprotein. The only other thing is she had an elevated screening blood sugar, but I gather at a normal follow-up her blood sugar was found to be normal. That's all I recall of that.

Q Based on those factors, in your opinion she was a complicated patient then as of the time she appeared for delivery?

A Correct.

Q Are the words or term "complicated obstetrical patient" defined anywhere?

A No.

Q Is that a matter of professional judgment as to whether or not a patient constitutes a complicated

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patient?
A I'm sorry. Say that question again.
Q Is that a matter of professional judgment then as to whether or not a patient constitutes a complicated obstetrical patient?
A I think a reasonable and prudent obstetrical practice would mark a patient who's had a previous C-section, who is going to have a trial at vaginal delivery, as complicated and high risk and someone you want to keep an eye on. But if you ask me are those words defined anywhere, probably not.
Q In your terminology, complicated patient and high risk patient are interchangeable or synonymous?
A Yes.
Q So she was a high risk patient?
A Correct.
Q You probably noted in the Certified Nurse-midwife Guidelines, which you've reviewed but don't have with you today, that certified nurse-midwives are approved to among other things supervise uncomplicated laboring patients. Correct?

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A Correct.
Q Are you critical of the fact that Susan Beach-Morgan was monitoring this patient after 7:30 p.m.?
A No.
Q Why not?
A Monitoring VBACs by a nurse-midwife is acceptable. It's an acceptable practice.
Q You do that within your practice?
A Yes.
Q Dr. Lowen, would you agree that although Ms. Yates' progress in her active phase of labor was slow it was, nevertheless, steady from 7:30 p.m. to midnight?
A Yes. Steady is the operative word, I guess, but she certainly made progress during that time. But I wouldn't designate that time particularly as a normal active phase, but -- okay. From 7:00 (sic) p.m. to 12, it was prolonged. It took her almost two hours per centimeter of dilatation that she made during that time, so I would probably agree with you

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in characterizing it as prolonged.
Q Are you critical of Susan Beach-Morgan's handling of Ms. Yates during that time period?
A You need to be more specific. In essence, are you talking to me about the fact that the patient was febrile?
Q When was it first noted that Ms. Yates developed a fever?
A Give me a minute, and I'll find that.
(Pause.)
A At 7:20.
Q 7:20 p.m.?
A 7:20 p.m.
Q And how was that situation handled?
A Her IV fluid rate was increased. They probably assumed that she was dehydrated.
Q Anything else?
A Well, she was getting ampicillin, and she was given ampicillin throughout the labor on the presumption that her group B strep status was unknown, so she was being managed with ampicillin and received

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a total of 10 grams during that time. I don't have any indication whether or not they were treating her fever, but it appears that they were giving her this regimen based on her undetermined beta strep status.
Q Was increasing the fluid rate and the ampicillin appropriate steps to take in the face of the fever?
A Initially, yes.
Q What was the highest temperature noted in the chart? This wasn't a significant fever, was it?
A 100.3.
Q Is that significant, in your opinion?
A By itself?
Q Correct.
A No.
Q Are you critical of the manner in which Susan Beach-Morgan handled that situation?
A Well, now we're going to get to the point where I feel that at this particular point she should have drawn a white blood count, and I think she should have notified the physician.

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Q In your opinion, would notifying a physician have resulted in any different action being taken?
A Other than he might have ordered a blood count, and they might have done cervical cultures. Probably at this time, it would not have changed the management, other than he would have been alerted to the fact that there was an elevated sense of awareness or sense of concern about this patient.
Q The problem might have heightened the physician's awareness of the situation, but in your judgment there probably would have been no change in the management?
A At this point, probably not.
Q By the way I meant to ask you earlier in the course of your reviewing medical-legal cases, have you on other occasions become involved in cases involving nurse-midwives?
A No.
Q Either for or against?
A No. I guess the only thing that I would be more specific about that is if I'm not mistaken the

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hospital that I reviewed a practice for, I think that hospital might have had nurse-midwives as part of their team but there was nothing regarding the nurse-midwives' management. It was the fact that they needed an in-house hospitalist because of the volume of patients they were seeing. That was the only other time.
Q Dr. Lowen, based upon your review of the strips, when in your opinion was the first nonreassuring tracing?
(Pause.)
A Between 5:00 p.m. and 6:00 p.m.
Q What page?
A 165. I think the tracing was acceptable, as is page 166. It showed good beat-to-beat variability, and a minimal amount of occasional early deceleration. I think as we go to page 167, which brings us to 5:30, 5:20, and we move on --
Q Are we talking p.m. or a.m.?
A This is all p.m., I am pretty sure. Let me make sure -- this is p.m. She begins to have some

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loss of beat-to-beat variability. And I think when we turn to page 172, they are beginning to try some intrauterine resuscitation, because it looks like they turn the patient to the left side.
Q Is that appropriate?
A Yes. The baseline also shifts then from around 150 to 130 to 140 and sort of flattens out, and she begins to have early decelerations with almost each contraction. The tracing stays flatter, less reactive, than previously.
Q What page are you on now, or pages?
A Up to 176. At 177, she has an early deceleration down to a rate of 90. However, in fairness she does have an acceleration after that.
Q A good recovery?
A A good recovery. Now I have a question on page 178. On 178, to me it looks like they either lost the -- there was a drop out of the fetal heart, or she had another bradycardia to 90, at which time to me they tried turning her on her side again. To me it looks like it's the right side. It's not

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inappropriate to be trying to break the patterns of decelerations. We move on to 179 and 180, and it's flattening out again.
Q And again, all up until this time the fetal heart tones are within the normal range?
A Correct.
Q With the one or two exceptions you pointed out that were bradycardic?
A Correct. That is a normal range in terms of the rate. It's hard to look at tracings page by page. So when you look at it sort of across the room and you see acceleration and then you begin to see it's flattening, in itself it may mean the baby is in a sleep phase. On the other hand, you just can't always attribute it to that and begin to think is there anything else going on. Then we move to pages 37 and 38.
Q Hang on. You lost the numbering.
A Yes. The numbering changes.
Q Let me flip over.
A So on page 37, there are a couple of early

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decels. On 38, there's another early, maybe a little bit of a variable component, slow recovery, again a little flattening. If you flip the page to 39, I think they do turn her to her side again. I think they get a little improvement. Maybe a variable with the middle contraction on that page, and then certainly another early, with a late component, and a slow recovery.

And now I'm back to page 40. Early -- they reposition the patient, I guess, in the middle of the page because the monitor comes. And now if I look at page 40 and page 41, very similar, and I think that this is either reflecting a dropout -- but it's concerning that this might be certainly a variable to late deceleration, the middle contraction on that page. One of the folded down pages, page 42, I think I folded down this page -- now I know why -- probably to get the dilatation. The tracing is not remarkably unusual. It's a lit bit more of the same. Actually, it's a better page than before, but I turned it down because it told me that she was six centimeters at

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this time and the time was 7:30.

Q That page 42 was, I think, the first time you see Susan Beach-Morgan's handwritten note on the strip?

A That is correct. That is the time that I assume that she took over, somewhere around 6:30, although in the deposition somewhere it says she came in at 6:30, but I think she took over at 7:30.

Q Are you saying that even before she came on duty there were some nonreassuring signs in these?

A Yes. So she takes over, and if we go to page 48, we are now a little after 8:00, and the patient is again starting with flattening of her beat-to-beat. The two or three pages before that were reasonable. But then on pages 47 and 48, again, she starts with earlies, some variable deceleration, some loss of beat-to-beat, and again they try repositioning her. At 10:20, it looks like the next page is page 49 --

Q I think that's 8:20.

A I'm sorry, 8:20 -- more flattening, earlies

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with variables, with slow recovery, little loss of beat-to-beat, and the contractions have some type of a deceleration with each contraction. Page 53, again, three contractions, three decelerations, reposition the patient again, flattening of the beat-to-beat. Page 54 is a good example of loss of beat-to-beat variability. Very sort of nonreactive. That's at 8:50 p.m. I folded back page 57 because, again, I see that I wanted to note the examination, and that was two hours since she was examined before and she's still at six centimeters. That's an indication certainly that instead of the one centimeter an hour that you would have expected, she's taken two hours and she's still the same and not made any progress since the previous exam. And some decelerations on that page.

On page 59, the decelerations are now -- if you look at the fetal heart deceleration, the first one looks like it's after the contraction, the peak of the contractions. So that's a little worrisome, because that's not an early anymore. That's

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definitely a variable with a possibly late component. And the last deceleration on that page starts probably just at or before the contraction has a late-looking sweep to it, so I would say that's a late deceleration.

Q What about the recovery on that one?

A The recovery -- the rate gets back to 150 but it trails off again, as you see, and it drops below the baseline and comes up. It's not acute. It does recover. It's not acute. Looking at page 60, again, we are getting the feeling that the peaks of the decelerations are occurring after the peaks of the contractions on two of those, certainly, putting them to variable, and a little improvement in beat-to-beat but still having decels. On page 64, she flattens out again with early decels, and page 67 there are variable decelerations. Tell me what you want me to do in the interest of time.

Q Sure. I guess what I want to get at here since you do have some time limitations is the fact that in your letter which we've marked as Exhibit No.

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2 you note at the bottom of the first page the patient made extremely slow progress during the active phase of her labor, became febrile, and had a nonreassuring tracing approximately two hours prior to delivery. So you obviously thought that was significant when you wrote this letter. When I was leading into this I started at a much earlier point in time in review of the strips, but in your letter you focused on the two-hour period before the delivery.

A Okay.

Q But it's your opinion, I take it, that even before this two-hour period before she is delivered at 7:16 a.m., in your opinion there were nonreassuring signs?

A Correct.

Q As a general matter, would you agree that the review or evaluation of fetal heart strips is a subjective undertaking and experts can disagree about the significance of the patterns?

A Absolutely.

Q I guess I would like to shift the focus.

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Generally speaking --

A However, I would like to add that even though you are correct about that, that fetal interpretations by different practitioners might be interpreted differently, there is a level of concern because of the patient's slow progress and because of the fact that her tracings are not reassuring, and there has to be a heightened level of concern somewhere along the line between the late evening and early into the morning regarding this.

Q And in your opinion what do you believe the standard of care requires on the face of this heightened level of concern?

A At minimal, notifying the physician and physician back up.

Q In your opinion, had the physician been notified do you think the management of this patient would have been different or changed what occurred?

A Yes.

Q How so?

A Following the first febrile call about

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mildly elevated temperatures followed by a prolonged active phase and slow progress, I felt that a physician examining this patient might have elected to -- could have made two decisions at this time. The decision would have been to do a fetal scalp and say to heck with the tracing, I've got a good baby, or that he's had enough. In previous feedback, she's done okay but doesn't see delivery as being imminent, and somewhere along this time would have elected to do a repeat cesarean section.

Q Are you phrasing your answer in terms of might have or could have?

A Should have.

Q To a reasonable medical certainty, you think the standard of care would have required a physician to do one of two things, the fetal scalp or --

A The fetus needed to be further assessed in view of the face of the tracing and the slow progress. They needed to have additional assessment of the well-being of that fetus. If for whatever reason that wasn't forthcoming or the facility did not have the

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ability to do that --

Q Do what?

A Do a fetal scalp sampling or fetal scalp stimulation, which is another thing that could have been done, and then I think this patient should have been delivered. That doesn't even get me into the early morning, because I feel probably a little stronger as the morning went on.

Q In your letter you make reference to the fact that there were numerous though subtle indications of distress as of this time period that we've covered so far. We're getting, I guess, close to midnight. In your opinion, are these indications, in fact subtle, of the possibility of fetal distress?

A The early changes that I noted in the tracing, the early decelerations, taken totally by themselves taken out of context for this particular patient, were subtle. If you couple that with the fact this is a patient who is undergoing a trial of labor, who is making slow progress in the active phase of labor, has a temperature of undetermined origin, I

move from being subtle to a little bit more concerning.

Q In what time period?

A I think I would pin that down between 11:00 p.m. and 1:00 a.m.

Q Again, following along in your report you're focusing on that two-hour time period prior to delivery. Why was that time frame significant to you in this case?

A We're now moving to 5:00?

Q Right. We're jumping ahead, because it's almost 11:30 and I want to get to the crux of your opinions here.

A I know you want to take me there, but can I ask if we can back up just a little bit?

Q Sure, because I'm interested in getting all of your opinions.

A Okay. The recording of the patient's progress and pelvic exams are pretty good until 1:00 a.m. After 1:00 a.m., I find the charting difficult to assess where the patient is. However, despite good

contractions if she was eight centimeters dilated at 11:00 p.m. and a rim -- which most of us would think of as being nine cms to fully dilated at 1:00 a.m. -- it's not unreasonable from the nurse's note and the patient's complaint to feel that even though she started pushing at 2:40, she essentially went from 1:00 a.m. and it took her six hours to deliver her baby, and she had rim of cervix at 1:00 a.m.

Q You are measuring from --

A What's left.

Q Nine to 10 centimeters dilated until actual delivery, you're saying that that six-hour period was -- basically, you are using that as the second stage of labor?

A No. The second stage -- yes, correct.

Q The charting indicates she didn't become actually dilated until when?

A The charting indicates that she didn't become fully dilated until 4:50, so I could argue that from 1:00 a.m. when she was at rim until three hours and 50 minutes later she made no progress.

Q Minimal progress?

A Minimal to no progress, because a rim is a rim, is a rim, is a rim. A rim can be reduced at the last minute if you have to do a delivery. Again, that's not my thrust in this case, but that is certainly -- as you said there's a difference in interpretations of fetal monitor strips and there's also a difference in interpretation to a rim versus complete versus not so much fully dilated. I would imagine most people would agree on fully dilated.

Q And just so I'm clear even though you say it's not your thrust, the point that you're making here is, can you condense it down?

A The point I'm making is from 1:00 a.m. when she a rim, I have no recording of a pelvic until 4:10, 4:20, when she's checked by the nurse-midwife who said no, you're not fully dilated so don't push, and then 20 minutes later or 30 minutes later you're fully dilated and start pushing. I think that's an exceedingly long period for a VBAC not to make progress despite adequate contractions.

Q Are you critical of the fact that a pelvic exam was not done sooner than 4:10?

A Yes.

Q Are there risks associated with performing a pelvic exam --

A Yes.

Q -- at this point in time or this stage of the patient's labor?

A If you're talking about repeated pelvics in the face of ruptured membranes, yes. But we're trying to make a decision about a vaginal delivery versus an operative delivery in a patient who has a low-grade fever to begin with. I think someone needed to make a decision, should have made a decision, whether continuing the labor or delivering the patient was prudent behavior.

Q And now we're up to what point in time?

A We can move now to where you wanted to go. We can go to two hours prior to the delivery.

Q We'll say up until?

A 5:00.

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Q I'm just trying to put the end point in time. So you're saying as of?
A I'm critical of what went on between 1:00 a.m. and 4:50.
Q And someone during that period of time in your judgment -- the decision should have been made whether or not to --
A Whether the baby was fine and just slow labor because she's laboring like a first baby, or it's an obstructed labor, and/or the baby is in distress and needs to be delivered.
Q Would a scalp --
A A scalp sample would help. It wouldn't help if you made up your mind to do a cesarean section at that time, but it would help if you decide that you're going to continue.
Q Do you have an opinion as to what a scalp sample would have shown if taken sometime during that time frame between 1:00 and 4:00?
A No.
Q And with the benefit of hindsight, can you

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make an educated guess as to what a scalp sample would have shown during that time period?
A I would have thought that a scalp sample during that time period might have been nonreassuring. It probably would have been repeated again in 15 minutes, and if it was the same way they would have delivered the baby.
Q Let me ask one more question in this time frame.
A Sure.
Q Based on everything that you see in the chart as of let's say the pelvic exam that was done at around 4:10 or 4:20 in the morning, in your opinion could one have predicted the eventual outcome in this case?
A No. You're asking me -- I'm sorry. Say it one more time.
Q Based on everything that was known up until this point in time, approximately 4:10 to 4:20 in the morning, could the outcome have been predicted in this case, the cord compression?

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A No. Well, cord compression is one of the reasons which we didn't go into, but I know you've got expert witnesses that say that cord compression is a cause for certainly variable decelerations and sometimes even late.
Q But there are a number of other explanations for that as well?
A Correct.
Q All right. Focusing now on the point consistent with the statements in your --
A 4:30 was the time that the pelvic was done. It's in the nurse's notes. She's advised not to push at 4:30 because she's not dilated enough. The patient voiced understanding. At 4:50 she's checked by the nurse-midwife in the room, and she's told that she's complete and she starts pushing with the patient.
Q And this second stage of labor is defined as a time of complete dilation until delivery of the child, so at least according to the records the second stage begins at 4:50 a.m.?
A Correct.

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Q And what is your general opinion as to the significance of that two-hour time limit that's placed upon this second stage of labor?
A And that's been stated, I know, somewhere before, because I've read it in someone's deposition. That's an arbitrary benchmark that we certainly would look to see a patient deliver within that time. Do we allow patients to go over that time? Absolutely. Do patients deliver in an hour of being fully dilated? Absolutely.
Q And here where we have a patient who was gravida II and had an epidural going past that two-hour time frame is not in and of itself, it doesn't constitute negligence?
A No, it does not.
Q And I think the time frame here that we're dealing with in this lady's case was two hours and 26 minutes?
A Correct.
Q And so it's not your opinion that this is an absolute requirement that a patient must deliver

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within that two-hour time frame?
A That's correct.
Q During that two-hour time frame, you note in your letter that the baby passed meconium. What's the significance of that to you in the context of what's known as of 5:15 a.m.?
A I think that was a certainly less than subtle indication that this baby was suffering from -- considering its presentation, which was a vertex -- it wasn't a breach, it was a vertex of labor -- considering the position of the baby in labor, considering the tracings prior to this, I think that meconium at this point, thick meconium as it's documented, was an indication of fetal distress.
Q And based upon the passing of meconium at that time, in your opinion what did the standard of care require, as far as treatment of the patient and baby?
A I think the baby should have been delivered. And I will add, even though we've talked about it before and I wouldn't want it to be out of context,

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that certainly a fetal scalp for whatever reason it hadn't been done prior to this, if someone was going to at this particular point allow this patient to labor to have a vaginal delivery, they needed some way to assess the well-being of that baby. And at this point not to do any fetal scalp sampling or aggressive attempts to a vaginal delivery, I think the patient needed to be delivered.
Q And again with respect to meconium, you would agree it's possible to have passing of meconium staining and still have a perfectly healthy baby and not a problematic delivery?
A That's correct.
Q Is there a link between what was going on with the baby's heart tones at the time the meconium was passed?
A At 4:50, it's noted on page 22 that she's completely dilated. Prior to that, by the way, there is some indication on pages 21 and 22 that the patient is pushing already, and that is I guess noted in the nurse's notes somewhere.

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Q I see that on the strip, patient pushing, and that's on page 23?
A Correct. On page 23, she's pushing.
Q At 5:00?
A Right. It's written right over it. That particular strip in itself is not bad, except the end of it where she certainly develops a bradycardia down to 90 to 100 with a slow recovery and just about recovers before the next contraction starts. And the next contraction starts on page 24. She has a late deceleration, certainly late to variable, another late to variable deceleration. The baseline shifts again, probably down to -- well, let me correct that. I think the baseline is still 140 to 150, and now what we're seeing are the late decelerations down to 90 to 100. On page 28, she's continuing to push. Maybe a little shift in the baseline to 130-140. Actually, a loss of beat-to-beat variability on page 30. More decelerations. Patient is obviously pushing. The uterine tone is increasing because the uterine tone is up to -- although, again, I think it's an external

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monitor at this point, but --
Q What page are you on?
A I'm on page 33, and she at least has some earlies.
Q Now we're at 6:10 a.m. Correct?
A Correct.
Q Let me stop you there. The chart reflects that the meconium was noted about 5:15, and going back over these strips from about that time, 5:00 to 6:00, over the next hour is there anything in the baby's heart tones that is particularly concerning?
A I don't feel warm and fuzzy about the tracings at that time. I think that certainly she is having more of the same, and I would agree with you she's not any worse. But she's certainly having variables, a few earlies, some late components, some slow recovery. I'm concerned. I can't read on page -- if you go to page 33, it looks to me like the beat-to-beat is off. Although it doesn't appear flattening, there's something that's changing to me. The contraction in the middle of the page is an early.

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She's pushing with each contraction and, obviously, there's a concern to get her delivered. She does have a few good accelerations at the end of that page.

Q Let me ask you one more question. Up to this point in time -- again, tying into the meconium -- by itself it doesn't indicate fetal or neonatal jeopardy unless it's accompanied by some abnormal fetal heart rate, does it?

A The answer to your question is yes, but I'm not comfortable with the tracing from 5:00 until when it's turned off.

Q But those tracings I think you said were not different or significantly different from the tracings that preceded it?

A That I was not happy with either, correct. And that's an interpretation, I guess.

Q I didn't mean to interrupt you.

A So now we're at 6:12 and, again, I read as much as I can read about what's going on.

Q Have we come across anymore folded pages?

A No. I think we did all four before.

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Q I know you listed them at the very beginning of the deposition, but did we identify the significance of all of the folded pages? I think one was that she was six centimeters dilated?

A They were folded for the purpose of following the progress of her labor.

Q The dilation?

A Correct.

Q What about those yellow Post-it notes?

A Those were reflecting a change of the strip in a couple of places and illustrated some variable decelerations in her chart, and I think we covered that. Then we get to 6:12.

Q What page is that?

A 34. The writing is pushing per Susan Beach. And what bothers me is the external monitor, particularly at this particular point, because in my review since the letter to you I am concerned at this point what's fetal heart and what's maternal heart. Because on the anesthesia -- there was an anesthesia -- it's called -- let me see for sure to get it right. It's called labor and delivery flow sheet, page 317 in the records.

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Q What about that?

A There's a single notation of the maternal pulse being 134, normal temperature, so that the pulse is not -- and I'm just wondering if the maternal pulse was that high at this particular point in the labor, were they missing -- and subsequently we know they considered it on page 35 of the fetal heart tracing -- that they may have been picking up the maternal heart rates and not the fetal heart rates because they were not using a scalp electrode on this fetus. They purposely took the monitoring off. The nurse-midwife took the monitoring off in order to allow her to push in a bunch of different positions.

Q As a general matter, do you think it was below the standard of care to remove the monitor?

A Yes.

Q Is that because the monitor is that much more accurate than intermittent auscultation?

A I think that intermittent auscultation only gives you a snapshot of the fetal heart rate at the particular time you auscultate. And as we see, it's a question of whether you're listening to the maternal heart or the fetal heart. And so I think in the face of a labor that was certainly showing variable to late decelerations, this was not the time not to monitor this patient for the last hour and 10 minutes, I guess, or hour and 16 minutes.

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Q Apart from your concern over whether they were measuring the mother's or the fetal heart rate, was there anything else in the recordings once intermittent auscultation was used that leads you to be concerned about the fetus?

A There's a nurse's note that with each push more meconium is being seen. That's reconfirming my earlier concern. At 6:15, the monitor is off by Susan Beach, the fetal heart is checked by auscultation, by listening, and that's when I find following the nurse's notes quite difficult, because they are not in sequence, which I commented on in one of my letters.

Q Of what you do see there in the chart,

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albeit out of sequence, is there anything that raises a concern about the baby's heart rate?

A No.

Q Do you think that in your opinion had the monitoring been continued that it would have changed the management of the patient?

A We are now making some suppositions. The supposition that we're saying is that in truth the baby's heart rate was between 130 and 140. We have no way of reading whether or not there's any decelerations because it's not a continuous strip. So if you say that by itself, the answer is they would not have changed their management. On the other hand, if they were not monitoring the baby, but they were picking up a maternal pulse and/or with a continuous tracing seeing any bradycardial late decelerations, et cetera, and couldn't have an imminent vaginal delivery at 6:10 or 6:20 or 6:30, I think that they should have delivered that baby under that scenario. Under the scenario you asked me, just by measuring fetal heart rate as being the only criteria for fetal well-being

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at that time, no, they continued.

Q Do you have an opinion as to the latest point in time that the baby would have been salvageable to a reasonable medical probability?

A 6:10.

Q And after that point, what can you say about the salvageability?

A Obviously, the concern is when did this baby expire. If I delivered it either vaginally or by C-section or by operative vaginal delivery, forceps, et cetera, prior to it expiring then I would have had a live baby. That's what I think should have been done here. In my opinion, this was a compromised baby whose level of compromise we still have no way of knowing, other than monitor strips which you've indicated and I agree with you is left to interpretation.

I can't even find the cord blood that's recorded here. There's a stamp on page 186 of the cord blood. I can't even find those results, which would have told me the condition of the baby

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immediately prior to the delivery. I don't know when the baby expired. All I know is it was under stress and expired and had no reserve left that it could even be resuscitated.

Q Then what's the basis on which you identify the 6:10 a.m. time as last point in time?

A I'm going to assume that I had a baby with a fetal heart, so I'm assuming that I have a recorded fetal heart, that this was a fetal heart tracing, although albeit it was an external monitor, and that we would have at least had a baby with some Apgar at that point. And as I've said to you, my concern is that from -- again, that there was no consideration of an operative vaginal or an operative delivery from 5:00 a.m. on.

Q Let me shift gears just a little bit. Have you had a chance to look at the autopsy report?

A Yes.

Q And you noted that bacteroids were found in the lungs?

A Yes.

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Q Would you agree there was a fetal infection, gram negative rods?

A Yes.

Q First of all, the fact that these bacteroids were found in the lungs, is that significant to you?

A Significant that they got to the lungs by being aspirated out of the amniotic fluid. Although the membranes were ruptured, I think that the cavity that the baby remained in was infected.

Q Do you believe that fact contributed to the baby's death?

A Yes.

Q Describe to what extent you feel that infection contributed.

A In itself, I think chorioamnionitis in a term fetus who has now been in labor over 23 hours has to play on that baby's reserve. And I think that at 5:00, we were looking at a baby that had minimal to any reserve left, was in fetal distress for whatever reason, cord compression, chorioamnionitis for 20 hours, whatever. I don't think that baby could

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withstand the last two hours of labor pushing when we know that each push cuts off the circulation to the baby, even to a baby that's not compromised with no cord around the neck.

Q Even if the baby had been delivered say hypothetically at 6:00 a.m., or prior to that 6:10 a.m. time, do you have an opinion whether or not the infection would have acted on the baby's condition?

A Sure it would have, absolutely.

Q How so?

A I think that the baby would have needed to be resuscitated external to the mother, placed on appropriate IV antibiotics, would have had possibly a rocky course in the nursery, but I think it would have done better than it did.

Q In light of following in this hypothetical question of delivery at 6:00, in your opinion would that rocky course have included some neurological or respiratory compromise?

A I think we're reaching, and it's speculative. All of the above. I just I think

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that all of the above.

Q All of the above would be possible?

A Would be possible, right.

Q As opposed to probable?

A Right. And the reason I pushed in my letters to Donna Taylor-Kolis and I pushed in my reasoning for being here, is that I feel that there were a number of issues throughout the case that looked at at any one time by a fresh pair of eyes might have changed the direction in the management of -- because I think I commented it was in no way to take away or cast a disparaging remark on the nurse-midwives and their ability to deliver a VBAC. That was not my intent.

Q If we change the hypothetical and suggest an earlier time of delivery, would that have changed the prognosis of the baby in the face of this infection?

A Again, chorioamnionitis is a serious condition, and that's why we push hard to make this diagnosis early. If you have a term baby, as this baby was, not compromised, reasonable neonatal

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intensive care unit, reasonable people, I think if you give them a viable baby I think that they will be able to bring that baby around. Obviously, a rocky course with all the suppositions and the hypothetical things that we can say. On the other hand, if you give them a severely compromised baby or a stillborn, they've nothing to work with.

Q Could the chorioamnionitis have been diagnosed any time during the labor process?

A The level of suspicion -- you pointed out that the fever was never high, and I think that is correct. In itself, it was not. I don't have a white count on her. There's a question of whether or not someone should have added a second antibiotic if they felt -- and I think that she probably would have or he if the doctor had been notified -- would have added a second antibiotic if they felt that they were dealing with a baby that was having chorioamnionitis. But it changes the whole scenario, because if this was a patient who we made the diagnosis early of chorioamnionitis then she would have been delivered by

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anybody earlier, including the patient manager. She knew that she wouldn't sit with this patient this long.

Q And this earlier delivery improved the prognosis of treatment of the chorioamnionitis?

A Yes.

Q Are you aware of any statistics regarding the mortality of chorioamnionitis?

A No.

Q You're saying with respect to considering a second antibiotic in that 12-hour time frame that it would have made a difference in the condition of the fetus?

A Might.

Q It's possible?

A Yes. I wouldn't hang my reputation on it, but it might have.

Q I guess I'm going to wrap up here. I know we're past our time. But when you say that the baby likely would have had a rocky course had it been delivered, can you just outline the possible types of

problems you would expect to see in a baby with chorioamnionitis?

A Respiratory distress, certainly low Apgars at birth, the possibility of a bowel infection of the baby at birth, and pneumonia. But in a good level 2 or level 3 nursery, I think that these in a noncompromised term baby, I think these could be handled.

Q Do you have an opinion as to when the total occlusion of the umbilical cord occurred in this case?

A No. Was that in the pathology? I missed that if it was.

MS. TAYLOR-KOLIS: I would suggest to you, Dr. Lowen, that if you want to look at the autopsy that you can do that.

MR. RANKIN: Sure.

A Okay. I don't remember reading that. Let me look. It doesn't say it was occluded. It doesn't say there was a knot or anything here. So I'm assuming that what you're asking me is because the cord was around the neck, and she cut it. There was

one loop of cord around the neck, and she cut it, and that was the occlusion?

Q Right.

A We didn't go there.

Q That was implicit in my question. Do you have an opinion as to when that occurred?

A No. Or if it occurred.

Q Or if it did?

A It was around the neck -- whether it was a total occlusion or not.

Q I think there was some reference, either in Susan Beach-Morgan's deposition, that it was a tightened cord?

A One loop.

Q That doesn't necessarily mean --

A It doesn't occlude it. It certainly may account for the tracings that we saw, and somebody that's smarter than me will probably tell you that.

Q Would you agree that as of the time that Susan Beach-Morgan assumed the care of this patient, that up until that point in time the labor had been

proceeding normally?

A Yes.

Q That's all I have. Thank you very much.

MR. RANKIN: Anybody have any questions?

MR. HUFFMAN: I have no questions for the witness.

(Off the record.)

MR. HUFFMAN: I don't think we need a copy at this time.

MS. TAYLOR-KOLIS: Also, Dr. Lowen, you have the right to read your testimony.

THE WITNESS: Yes. I would like to see it written.

MS. TAYLOR-KOLIS: And I believe that you should see it.

We are not going to waive his right to read it. Send it to him, and I will take a regular size copy.

(The deposition concluded at 12:02 p.m.)

ACKNOWLEDGEMENT OF DEPONENT

I, Marc Lowen, M.D., do hereby acknowledge I have read and examined the foregoing pages of testimony, and the same is a true, correct, and complete transcription of the testimony given by me, and any changes and/or corrections, if any, appear in the attached errata sheet signed by me.

_____ _____

Date Marc Lowen, M.D.

CERTIFICATE OF NOTARY PUBLIC

I, Linda H. Cole, the officer before whom the foregoing deposition was taken, do hereby certify that the foregoing transcript is a true and correct record of the testimony given; that said testimony was taken by me stenographically and thereafter reduced to typewriting under my supervision; and that I am neither counsel for, related to, nor employed by any of the parties to this case and have no interest, financial or otherwise, in its outcome.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 26th day of December, 2002.

My commission expires July 1, 2006

NOTARY PUBLIC IN AND FOR
STATE OF MARYLAND

December 26, 2002
Marc Lowen, M.D.
6701 Park Heights Avenue, Apt. 4G
Baltimore, Maryland 21215
Re: Yates v. MedCentral Health System, et al.
Deposition of Marc Lowen, M.D.

Attached for your review and signature is a copy of the above-referenced deposition. We ask that you read the transcript carefully. If it is necessary to make any corrections, please do so on the enclosed errata sheet, indicating the page, line number, and correction. Also, you must sign the Acknowledgement of Deponent enclosed in the transcript.

Additionally, under the Maryland Rules, if you do not complete the reading and signing within 30 days, you may have waived your right to make corrections. Therefore, your prompt attention to this matter is greatly appreciated. Please return the transcript, the Acknowledgement of Deponent, and any errata sheets to our office at 401 E. Pratt Street, Suite 425, Baltimore, MD 21202.

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ERRATA SHEET

Case Name: Yates v. MedCentral Health System, et al.

Witness Name: Marc Lowen, M.D.
Deposition Date: December 19, 2002
Job No.: 149570

Page No.	Line No.	Correction	Reason for Correction

Signature _____ Date _____