

Marc Lowen, M.D.

<div>1 IN THE COURT OF COMMON PLEAS</div> <div>2 RICHLAND COUNTY, OHIO</div> <div>3 LISA M. YATES, ADMIN. FOR :</div> <div>4 THE ESTATE OF DYLAN JOHN :</div> <div>5 KING, DECEASED, ETC. : CASE NO. 01-389D</div> <div>6 Plaintiff : Judge DeWeese</div> <div>7 v. :</div> <div>8 MEDCENTRAL HEALTH SYSTEM, :</div> <div>9 et al. :</div> <div>10 Defendants : Pages 1 - 83</div> <div>11</div> <div>12 Deposition of Marc Lowen, M.D.</div> <div>13 Linthicum, Maryland</div> <div>14 Thursday, December 19, 2002</div> <div>15</div> <div>16</div> <div>17</div> <div>18</div> <div>19</div> <div>20</div> <div>21 Reported by: Linda H. Cole, Notary Public</div>	<div>Page 3</div> <div>1 APPEARANCES:</div> <div>2 DONNA TAYLOR-KOLIS, ESQUIRE, Via Telephone</div> <div>3 Third Floor - Standard Building</div> <div>4 1370 Ontario Street</div> <div>5 Cleveland, Ohio 44113</div> <div>6 (216) 621-0070</div> <div>7 On behalf of the Plaintiff</div> <div>8</div> <div>9 GREGORY D. RANKIN, ESQUIRE</div> <div>10 LANE, ALTON & HORST</div> <div>11 175 South Third Street</div> <div>12 Columbus, Ohio 43215</div> <div>13 (614) 228-6885</div> <div>14 On behalf of the Defendant, Susan Beach-Morgan</div> <div>15</div> <div>16 LAWRENCE S. HUFFMAN, ESQUIRE, Via Telephone</div> <div>17 127-129 North Pierce Street</div> <div>18 Lima, Ohio 45802</div> <div>19 (419) 227-3423</div> <div>20 On behalf of the Defendant, Women's Care of</div> <div>21 Mansfield, Inc.</div>
<div>Page 2</div> <div>1</div> <div>2</div> <div>3</div> <div>4</div> <div>5</div> <div>6</div> <div>7 December 19, 2002</div> <div>8 10:02 a.m.</div> <div>9</div> <div>10 Deposition of Marc Lowen, M.D. held at:</div> <div>11</div> <div>12</div> <div>13</div> <div>14 Sheraton International Hotel</div> <div>15 7032 Elm Road, BWI Airport</div> <div>16 Baltimore, Maryland 21240</div> <div>17</div> <div>18</div> <div>19</div> <div>20 Pursuant to notice, before Linda H. Cole, a Notary</div> <div>21 Public of the State of Maryland.</div>	<div>Page 4</div> <div>1 I N D E X</div> <div>2</div> <div>3 WITNESS PAGE</div> <div>4 MARC LOWEN, M.D.</div> <div>5 Examination By Mr. Rankin 5</div> <div>6</div> <div>7</div> <div>8</div> <div>9</div> <div>10</div> <div>11</div> <div>12 E X H I B I T S</div> <div>13 (Exhibits attached.)</div> <div>14 NUMBER DESCRIPTION PAGE</div> <div>15 1 Curriculum Vitae 5</div> <div>16 2 Letter Dated August 26, 2002 5</div> <div>17 3 Letter Dated August 28, 2002 23</div> <div>18 4 Photocopy of Handwritten Notes 23</div> <div>19</div> <div>20</div> <div>21</div>

1 (Pages 1 to 4)

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1 Thereupon,
2 MARC LOWEN, M.D.
3 a witness herein, called for oral examination in the
4 matter pending, being first duly sworn to tell the
5 truth, the whole truth and nothing but the truth,
6 testified as follows.
7 (Exhibit Nos. 1 and 2 premarked.)
8 EXAMINATION
9 BY MR. RANKIN:
10 Q Good morning, Dr. Lowen. My name is Greg
11 Rankin, and we just met a few moments ago. Let's
12 start by my handing you what we have marked as Lowen
13 Exhibit No. 1, which is your C.V. Is that relatively
14 up-to-date and current?
15 A Yes, that's current.
16 Q Let me ask you about a couple of
17 publications you have listed in your C.V. I note that
18 there are several that may pertain to the issues in
19 this case. The first one that I've highlighted there
20 is the Value of Fetal Monitoring. What is that?
21 A That was a letter to the editor commenting

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1 on a case that questioned whether or not fetal
2 monitoring was important, and my letter said that I
3 thought it was important.
4 Q This was written when?
5 A In 1977. A long time ago.
6 Q Now is that different from the publication
7 immediately above it on your C.V., where you indicate
8 a letter to the editor regarding maternal morbidity?
9 A That's a different letter; that's 1976. And
10 that was also a comment regarding a maternal death
11 case presentation, and I made some comments in a
12 letter to the editor.
13 Q I note that whereas in that publication in
14 the matter pertaining to the value of fetal
15 monitoring, you don't designate that as a letter to
16 the editor?
17 A I'm pretty sure that's a letter to the
18 editor.
19 Q And then the next publication that may bear
20 relevance to the issues in this case is the role of
21 midwives in the New England Journal of Medicine. What

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1 is that?
2 A That is a discussion -- I think that's also
3 a letter to the editor -- and that was regarding
4 nurse-midwives being trained at a program that also
5 was training obstetrical residents. The letter dealt
6 with whether or not we were diluting the patient pool
7 for the resident education by also running a
8 nurse-midwife training program at an institution that
9 was described in an article that I was commenting
10 about.
11 Q What was your position in that regard?
12 A My position in that particular program was
13 that they should concentrate on educating residents
14 and not continue with their nurse-midwife program.
15 Q Philosophically what is your current
16 attitude towards the role of midwives?
17 A I think that they are a valuable asset to
18 obstetrical practices.
19 Q Does your practice involve the use of
20 midwives?
21 A Yes.

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1 Q How much?
2 A We have one nurse-midwife in our practice.
3 Q Historically has that --
4 A She's been the only one. We've had her for
5 probably 12 to 14 years.
6 Q How big is your group?
7 A The group is four of us -- five, including
8 the nurse-midwife. Two practicing OBs and three
9 practicing gynecology, currently.
10 Q And approximately, how many babies per year
11 does the group deliver?
12 A About 230.
13 Q And over the last five years, has that
14 number stayed the same?
15 A No. It's increased.
16 Q Five years ago, how many were you
17 delivering?
18 A Five years ago, we were probably delivering
19 180.
20 Q And what percentage of those deliveries
21 involved midwives?

2 (Pages 5 to 8)

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

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

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1 Q And within that private practice, how do you
2 spend your time, obstetrics or gynecology or both?
3 A Gynecology.
4 Q Exclusively?
5 A Exclusively.
6 Q Has it always been true that your private
7 practice has been devoted to the practice of
8 gynecology?
9 A No.
10 Q When did that come about?
11 A 1998 was the last time I did obstetrics in
12 private practice.
13 Q When did you last deliver a baby in private
14 practice?
15 A In 1998.
16 Q Why did you leave or change the focus of
17 your practice from obstetrics to gynecology?
18 A First of all, I thought it was time in my
19 life to do that, and I had the opportunity to be the
20 residents' director at Sinai.
21 Q Is that when you took that position in 1998?

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

3 (Pages 9 to 12)

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

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

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

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

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

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

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

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

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

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

17 A I would say 75 percent is administrative and
18 25 percent is teaching.

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

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

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

7 Q How frequently do you do that?

8 A Six times a year.

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

11 A Minimal.

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

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

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

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

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

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

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

21 Q Over what time frame?

4 (Pages 13 to 16)

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1 A Ten years.
2 Q '70s or '80s?
3 A Yes. More between '80 and '90.
4 Q And then as a result of or subsequent to
5 that, you started to review cases involving medical
6 malpractice?
7 A Yes.
8 Q So, again this is an approximation, but
9 sometime in the late '80s or early '90s you first
10 reviewed medical malpractice claims on behalf of
11 either patients or physicians?
12 A Correct. It would probably by the early
13 '90s.
14 Q What percentage of the cases that you looked
15 at were review on behalf of the patient and what
16 percentage on behalf of the physician?
17 A About 80 percent on behalf of the physician
18 and 20 percent on behalf of the plaintiff.
19 Q Are you affiliated with any medical expert
20 consulting services?
21 A No.

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1 Q Do you advertise?
2 A Absolutely not.
3 Q How did you happen to be selected to become
4 involved in this particular case?
5 A I'm pretty sure that I responded to a flyer
6 from Donna Taylor-Kolis' office.
7 Q Do you know when you received the flyer?
8 A I would have to say that it would have to be
9 '99 or 2000. May '99, but I'm not exactly sure.
10 Q What was the nature of the flyer as you call
11 it?
12 A I actually had to be reminded of that,
13 because I didn't remember initially how we met. But I
14 think it asked about -- I think that the flyer got to
15 me because I was a program director of a residency
16 program, and I guess the question was asked would you
17 be willing to read malpractice cases. And I called
18 and responded that I would, but certainly on a limited
19 basis. I don't have enough time to do it on more than
20 a limited time basis.
21 Q And when were you asked specifically to

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1 become involved in this case and review the records?
2 A I don't remember the month, but I'm pretty
3 sure it was 2000. It probably was the end of '99 or
4 the beginning of 2000, because my letter to Donna
5 Taylor-Kolis was August 28th, 2000 so I must have had
6 the case prior to that.
7 Q By the way, what percentage of your income
8 is derived from performing medical-legal consulting?
9 A Based on the numbers that I told you,
10 minimally.
11 Q Less than five percent, 10 percent? If you
12 know.
13 A Less than five percent.
14 Q You were asked to bring certain documents
15 here with you today, and let me go through the list.
16 All the materials and records that you reviewed to
17 form the basis of your opinion which you intend to
18 render at trial?
19 A Correct. There is one document that I do
20 not have with me. Donna had sent it out to me I'm
21 embarrassed to say probably twice, and it's still not

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

5 (Pages 17 to 20)

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1 and the physicians at Mansfield Obstetrics &
2 Gynecology Associates, Inc., is dated September 8th,
3 1999. Correct?
4 A Correct.
5 Q It's a six-page document?
6 A Correct.
7 Q You have a deposition transcript of Ms.
8 Susan Smith taken 12/3/02, the report of Dr. Elliott
9 dated September 3, 2002, the report of Joyce Roberts
10 dated September 12th, 2002.
11 A And a copy of my letter that I originally
12 wrote to them.
13 Q There's a cover letter from Ms. Donna
14 Taylor-Kolis, and just let me identify it. There's a
15 cover letter from Donna Taylor-Kolis dated September
16 23rd, 2002, enclosing the reports of Ms. Roberts and
17 Dr. Elliott. And I will just reach across here for
18 Dr. Lowen's handwritten notes on the front of one
19 page, and then there's a letter to Donna dated August
20 28th, 2000, a three-page letter, regarding his review
21 of some of the materials in connection with this case.

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1 A That was before I -- I didn't have -- there
2 are new materials that I've gotten since then.
3 Q Correct me if I'm wrong, but this letter
4 that is dated August 28th, 2000, I assume reflects
5 your preliminary opinions that you formed after
6 reviewing the medical records, and then after you
7 wrote this letter you received deposition transcript
8 reports and other materials?
9 A Correct.
10 Q Those materials have not caused you to
11 change the opinions that are contained in the August
12 28th, 2000 letter?
13 A No.
14 Q I have everything else, but I would like to
15 mark -- I don't know if they have copying capabilities
16 here at the hotel -- but can I put a sticker on this
17 for now and we'll worry about copies later?
18 A You can have this.
19 Q The typed letter?
20 A Right. And this, I just need to refer to
21 but you can have that when I'm finished.

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1 (Exhibit Nos. 3 and 4 marked.)
2 Q Other than this case, have you reviewed any
3 other cases for Donna or members of her firm?
4 A I think one other, but I hope you're not
5 going to ask me to tell you about it because I don't
6 recall. But if Donna is there she might recall, but I
7 don't recall.
8 Q I assume that was on behalf of a patient, a
9 plaintiff suing a physician?
10 A That I think was on a plaintiff again, yes.
11 Q Have you reviewed any other cases for any
12 attorneys other than Donna in Ohio?
13 A I don't think so.
14 Q I assume you don't know Donna?
15 A I have in Florida -- know her?
16 Q Yes. Other than through reviewing cases for
17 her, any member of her firm or family member or friend
18 or associate that you had contact with?
19 A None at all.
20 Q From her firm?
21 A Her firm? I had contact with a gentleman by

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1 the name of Chris.
2 THE WITNESS: Right, Donna? Chris is
3 the one who talks to me?
4 MS. TAYLOR-KOLIS: He's my paralegal.
5 Q You mentioned that you have reviewed --
6 other than these cases, assuming there are two of them
7 in Ohio, you have reviewed cases in Florida?
8 A Florida.
9 Q Any other states?
10 A Florida sticks out, and I don't recall. I
11 have reviewed in the State of Maryland, yes.
12 Q Do you know approximately how many cases
13 that you've reviewed have involved claims of medical
14 malpractice here in Maryland?
15 A Five.
16 Q How about in Florida?
17 A Two -- let me correct that. Malpractice
18 would mean I would be reading for the plaintiff?
19 Q Well, either.
20 A In Florida, I read for the hospital. It was
21 to look at a group practice that had some

6 (Pages 21 to 24)

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

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

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

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

21 A Never.

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1 Q On how many occasions have you given
2 depositions?

3 A Twice.

4 Q Is this your second deposition?

5 A Second.

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

9 A Yes, I have been asked.

10 Q Have you agreed to do that?

11 A Yes.

12 Q What do you charge for your professional
13 time?

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

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

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

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

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

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

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

13 A No.

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

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

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

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

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

8 A No.

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

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

14 Q This is the earliest letter?

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

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

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

7 (Pages 25 to 28)

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

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

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

9 A No.

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

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

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

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1 on?

2 A 36 and 2.

3 Q Prior to this case --

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

5 Q A Post-it note?

6 A Yes.

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

9 A No.

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

12 A No.

13 Q Dr. John Elliott?

14 A No.

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

17 A No.

18 Q Have you ever been there?

19 A Sure, Cincinnati.

20 Q That's in Ohio.

21 A And Cleveland. I have some friends in

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

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

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

8 Q Why did you do that?

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

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

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

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

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

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

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1 Cleveland and family in Cincinnati.

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

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

6 Q Yes. What did I say?

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

10 Q You are licensed to practice medicine?

11 A Yes, absolutely.

12 Q Your license is in good standing?

13 A Yes.

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

16 A No.

17 Q Directing your attention, Dr. Lowen, to
18 Exhibit No. 2, which is your letter of August 26th,
19 2002. Am I correct that this letter basically
20 summarizes all the opinions that you've formulated in
21 this case following your review of the medical

8 (Pages 29 to 32)

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

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

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

12 A Okay.

13 Q I was going to the more recent letter.

14 A Just give me a minute to read it.

15 (Witness reading.)

16 A Restate the question.

17 Q That was that long-winded question. Let me
18 rephrase it a little bit. Does this letter of August
19 26th, 2002, which we have marked as Exhibit No. 2,
20 reflect your current opinions after you have reviewed
21 all the materials before us today?

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1 A Correct.

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

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

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

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

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

16 A Absolutely.

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

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

4 A Five, I think.

5 Q Do you know how many appointments she made?

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

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

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

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1 planned to have.

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

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

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

16 A Correct.

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

19 A No.

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

9 (Pages 33 to 36)

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Page 37

1 patient?

2 A I'm sorry. Say that question again.

3 Q Is that a matter of professional judgment
4 then as to whether or not a patient constitutes a
5 complicated obstetrical patient?

6 A I think a reasonable and prudent obstetrical
7 practice would mark a patient who's had a previous
8 C-section, who is going to have a trial at vaginal
9 delivery, as complicated and high risk and someone you
10 want to keep an eye on. But if you ask me are those
11 words defined anywhere, probably not.

12 Q In your terminology, complicated patient and
13 high risk patient are interchangeable or synonymous?

14 A Yes.

15 Q So she was a high risk patient?

16 A Correct.

17 Q You probably noted in the Certified
18 Nurse-midwife Guidelines, which you've reviewed but
19 don't have with you today, that certified
20 nurse-midwives are approved to among other things
21 supervise uncomplicated laboring patients. Correct?

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1 A Correct.

2 Q Are you critical of the fact that Susan
3 Beach-Morgan was monitoring this patient after 7:30
4 p.m.?

5 A No.

6 Q Why not?

7 A Monitoring VBACs by a nurse-midwife is
8 acceptable. It's an acceptable practice.

9 Q You do that within your practice?

10 A Yes.

11 Q Dr. Lowen, would you agree that although Ms.
12 Yates' progress in her active phase of labor was slow
13 it was, nevertheless, steady from 7:30 p.m. to
14 midnight?

15 A Yes. Steady is the operative word, I guess,
16 but she certainly made progress during that time. But
17 I wouldn't designate that time particularly as a
18 normal active phase, but -- okay. From 7:00 (sic)
19 p.m. to 12, it was prolonged. It took her almost two
20 hours per centimeter of dilatation that she made
21 during that time, so I would probably agree with you

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1 in characterizing it as prolonged.

2 Q Are you critical of Susan Beach-Morgan's
3 handling of Ms. Yates during that time period?

4 A You need to be more specific. In essence,
5 are you talking to me about the fact that the patient
6 was febrile?

7 Q When was it first noted that Ms. Yates
8 developed a fever?

9 A Give me a minute, and I'll find that.

10 (Pause.)

11 A At 7:20.

12 Q 7:20 p.m.?

13 A 7:20 p.m.

14 Q And how was that situation handled?

15 A Her IV fluid rate was increased. They
16 probably assumed that she was dehydrated.

17 Q Anything else?

18 A Well, she was getting ampicillin, and she
19 was given ampicillin throughout the labor on the
20 presumption that her group B strep status was unknown,
21 so she was being managed with ampicillin and received

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1 a total of 10 grams during that time. I don't have
2 any indication whether or not they were treating her
3 fever, but it appears that they were giving her this
4 regimen based on her undetermined beta strep status.

5 Q Was increasing the fluid rate and the
6 ampicillin appropriate steps to take in the face of
7 the fever?

8 A Initially, yes.

9 Q What was the highest temperature noted in
10 the chart? This wasn't a significant fever, was it?

11 A 100.3.

12 Q Is that significant, in your opinion?

13 A By itself?

14 Q Correct.

15 A No.

16 Q Are you critical of the manner in which
17 Susan Beach-Morgan handled that situation?

18 A Well, now we're going to get to the point
19 where I feel that at this particular point she should
20 have drawn a white blood count, and I think she should
21 have notified the physician.

10 (Pages 37 to 40)

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1 Q In your opinion, would notifying a physician
2 have resulted in any different action being taken?

3 A Other than he might have ordered a blood
4 count, and they might have done cervical cultures.
5 Probably at this time, it would not have changed the
6 management, other than he would have been alerted to
7 the fact that there was an elevated sense of awareness
8 or sense of concern about this patient.

9 Q The problem might have heightened the
10 physician's awareness of the situation, but in your
11 judgment there probably would have been no change in
12 the management?

13 A At this point, probably not.

14 Q By the way I meant to ask you earlier in the
15 course of your reviewing medical-legal cases, have you
16 on other occasions become involved in cases involving
17 nurse-midwives?

18 A No.

19 Q Either for or against?

20 A No. I guess the only thing that I would be
21 more specific about that is if I'm not mistaken the

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1 loss of beat-to-beat variability. And I think when we
2 turn to page 172, they are beginning to try some
3 intrauterine resuscitation, because it looks like they
4 turn the patient to the left side.

5 Q Is that appropriate?

6 A Yes. The baseline also shifts then from
7 around 150 to 130 to 140 and sort of flattens out, and
8 she begins to have early decelerations with almost
9 each contraction. The tracing stays flatter, less
10 reactive, than previously.

11 Q What page are you on now, or pages?

12 A Up to 176. At 177, she has an early
13 deceleration down to a rate of 90. However, in
14 fairness she does have an acceleration after that.

15 Q A good recovery?

16 A A good recovery. Now I have a question on
17 page 178. On 178, to me it looks like they either
18 lost the -- there was a drop out of the fetal heart,
19 or she had another bradycardia to 90, at which time to
20 me they tried turning her on her side again. To me it
21 looks like it's the right side. It's not

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1 hospital that I reviewed a practice for, I think that
2 hospital might have had nurse-midwives as part of
3 their team but there was nothing regarding the
4 nurse-midwives' management. It was the fact that they
5 needed an in-house hospitalist because of the volume
6 of patients they were seeing. That was the only other
7 time.

8 Q Dr. Lowen, based upon your review of the
9 strips, when in your opinion was the first
10 nonreassuring tracing?

11 (Pause.)

12 A Between 5:00 p.m. and 6:00 p.m.

13 Q What page?

14 A 165. I think the tracing was acceptable, as
15 is page 166. It showed good beat-to-beat variability,
16 and a minimal amount of occasional early deceleration.
17 I think as we go to page 167, which brings us to 5:30,
18 5:20, and we move on --

19 Q Are we talking p.m. or a.m.?

20 A This is all p.m., I am pretty sure. Let me
21 make sure -- this is p.m. She begins to have some

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1 inappropriate to be trying to break the patterns of
2 decelerations. We move on to 179 and 180, and it's
3 flattening out again.

4 Q And again, all up until this time the fetal
5 heart tones are within the normal range?

6 A Correct.

7 Q With the one or two exceptions you pointed
8 out that were bradycardic?

9 A Correct. That is a normal range in terms of
10 the rate. It's hard to look at tracings page by page.
11 So when you look at it sort of across the room and you
12 see acceleration and then you begin to see it's
13 flattening, in itself it may mean the baby is in a
14 sleep phase. On the other hand, you just can't always
15 attribute it to that and begin to think is there
16 anything else going on. Then we move to pages 37 and
17 38.

18 Q Hang on. You lost the numbering.

19 A Yes. The numbering changes.

20 Q Let me flip over.

21 A So on page 37, there are a couple of early

11 (Pages 41 to 44)

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

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

Page 47

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

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

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1 this time and the time was 7:30.

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

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

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

11 A Yes. So she takes over, and if we go to
12 page 48, we are now a little after 8:00, and the
13 patient is again starting with flattening of her
14 beat-to-beat. The two or three pages before that were
15 reasonable. But then on pages 47 and 48, again, she
16 starts with earlies, some variable deceleration, some
17 loss of beat-to-beat, and again they try repositioning
18 her. At 10:20, it looks like the next page is page
19 49 --

20 Q I think that's 8:20.

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

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

6 Q What about the recovery on that one?

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

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

12 (Pages 45 to 48)

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1 2 you note at the bottom of the first page the patient
2 made extremely slow progress during the active phase
3 of her labor, became febrile, and had a nonreassuring
4 tracing approximately two hours prior to delivery. So
5 you obviously thought that was significant when you
6 wrote this letter. When I was leading into this I
7 started at a much earlier point in time in review of
8 the strips, but in your letter you focused on the
9 two-hour period before the delivery.

10 A Okay.

11 Q But it's your opinion, I take it, that even
12 before this two-hour period before she is delivered at
13 7:16 a.m., in your opinion there were nonreassuring
14 signs?

15 A Correct.

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

20 A Absolutely.

21 Q I guess I would like to shift the focus.

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

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

13 A Should have.

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

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

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1 Generally speaking --

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

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

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

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

19 A Yes.

20 Q How so?

21 A Following the first febrile call about

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1 ability to do that --

2 Q Do what?

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

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

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

13 (Pages 49 to 52)

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1 move from being subtle to a little bit more
2 concerning.

3 Q In what time period?

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

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

10 A We're now moving to 5:00?

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

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

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

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

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1 Q Minimal progress?

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

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

14 A The point I'm making is from 1:00 a.m. when
15 she a rim, I have no recording of a pelvic until 4:10,
16 4:20, when she's checked by the nurse-midwife who said
17 no, you're not fully dilated so don't push, and then
18 20 minutes later or 30 minutes later you're fully
19 dilated and start pushing. I think that's an
20 exceedingly long period for a VBAC not to make
21 progress despite adequate contractions.

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1 contractions if she was eight centimeters dilated at
2 11:00 p.m. and a rim -- which most of us would think
3 of as being nine cms to fully dilated at 1:00 a.m. --
4 it's not unreasonable from the nurse's note and the
5 patient's complaint to feel that even though she
6 started pushing at 2:40, she essentially went from
7 1:00 a.m. and it took her six hours to deliver her
8 baby, and she had rim of cervix at 1:00 a.m.

9 Q You are measuring from --

10 A What's left.

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

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

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

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

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

3 A Yes.

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

6 A Yes.

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

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

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

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

20 Q We'll say up until?

21 A 5:00.

14 (Pages 53 to 56)

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

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

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

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

15 (Pages 57 to 60)

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1 within that two-hour time frame?

2 A That's correct.

3 Q During that two-hour time frame, you note in
4 your letter that the baby passed meconium. What's the
5 significance of that to you in the context of what's
6 known as of 5:15 a.m.?

7 A I think that was a certainly less than
8 subtle indication that this baby was suffering from --
9 considering its presentation, which was a vertex -- it
10 wasn't a breach, it was a vertex of labor --
11 considering the position of the baby in labor,
12 considering the tracings prior to this, I think that
13 meconium at this point, thick meconium as it's
14 documented, was an indication of fetal distress.

15 Q And based upon the passing of meconium
16 at that time, in your opinion what did the standard of
17 care require, as far as treatment of the patient and
18 baby?

19 A I think the baby should have been delivered.
20 And I will add, even though we've talked about it
21 before and I wouldn't want it to be out of context,

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1 that certainly a fetal scalp for whatever reason it
2 hadn't been done prior to this, if someone was going
3 to at this particular point allow this patient to
4 labor to have a vaginal delivery, they needed some way
5 to assess the well-being of that baby. And at this
6 point not to do any fetal scalp sampling or aggressive
7 attempts to a vaginal delivery, I think the patient
8 needed to be delivered.

9 Q And again with respect to meconium, you
10 would agree it's possible to have passing of meconium
11 staining and still have a perfectly healthy baby and
12 not a problematic delivery?

13 A That's correct.

14 Q Is there a link between what was going on
15 with the baby's heart tones at the time the meconium
16 was passed?

17 A At 4:50, it's noted on page 22 that she's
18 completely dilated. Prior to that, by the way, there
19 is some indication on pages 21 and 22 that the patient
20 is pushing already, and that is I guess noted in the
21 nurse's notes somewhere.

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1 Q I see that on the strip, patient pushing,
2 and that's on page 23?

3 A Correct. On page 23, she's pushing.

4 Q At 5:00?

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

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1 monitor at this point, but --

2 Q What page are you on?

3 A I'm on page 33, and she at least has some
4 earlies.

5 Q Now we're at 6:10 a.m. Correct?

6 A Correct.

7 Q Let me stop you there. The chart reflects
8 that the meconium was noted about 5:15, and going back
9 over these strips from about that time, 5:00 to 6:00,
10 over the next hour is there anything in the baby's
11 heart tones that is particularly concerning?

12 A I don't feel warm and fuzzy about the
13 tracings at that time. I think that certainly she is
14 having more of the same, and I would agree with you
15 she's not any worse. But she's certainly having
16 variables, a few earlies, some late components, some
17 slow recovery. I'm concerned. I can't read on
18 page -- if you go to page 33, it looks to me like the
19 beat-to-beat is off. Although it doesn't appear
20 flattening, there's something that's changing to me.
21 The contraction in the middle of the page is an early.

16 (Pages 61 to 64)

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1 She's pushing with each contraction and, obviously,
2 there's a concern to get her delivered. She does have
3 a few good accelerations at the end of that page.
4 Q Let me ask you one more question. Up to
5 this point in time -- again, tying into the
6 meconium -- by itself it doesn't indicate fetal or
7 neonatal jeopardy unless it's accompanied by some
8 abnormal fetal heart rate, does it?
9 A The answer to your question is yes, but I'm
10 not comfortable with the tracing from 5:00 until when
11 it's turned off.
12 Q But those tracings I think you said were not
13 different or significantly different from the tracings
14 that preceded it?
15 A That I was not happy with either, correct.
16 And that's an interpretation, I guess.
17 Q I didn't mean to interrupt you.
18 A So now we're at 6:12 and, again, I read as
19 much as I can read about what's going on.
20 Q Have we come across anymore folded pages?
21 A No. I think we did all four before.

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1 Q I know you listed them at the very beginning
2 of the deposition, but did we identify the
3 significance of all of the folded pages? I think one
4 was that she was six centimeters dilated?
5 A They were folded for the purpose of
6 following the progress of her labor.
7 Q The dilation?
8 A Correct.
9 Q What about those yellow Post-it notes?
10 A Those were reflecting a change of the strip
11 in a couple of places and illustrated some variable
12 decelerations in her chart, and I think we covered
13 that. Then we get to 6:12.
14 Q What page is that?
15 A 34. The writing is pushing per Susan
16 Beach. And what bothers me is the external monitor,
17 particularly at this particular point, because in my
18 review since the letter to you I am concerned at this
19 point what's fetal heart and what's maternal heart.
20 Because on the anesthesia -- there was an
21 anesthesia -- it's called -- let me see for sure to

Page 67

1 get it right. It's called labor and delivery flow
2 sheet, page 317 in the records.
3 Q What about that?
4 A There's a single notation of the maternal
5 pulse being 134, normal temperature, so that the pulse
6 is not -- and I'm just wondering if the maternal pulse
7 was that high at this particular point in the labor,
8 were they missing -- and subsequently we know they
9 considered it on page 35 of the fetal heart tracing --
10 that they may have been picking up the maternal heart
11 rates and not the fetal heart rates because they were
12 not using a scalp electrode on this fetus. They
13 purposely took the monitoring off. The nurse-midwife
14 took the monitoring off in order to allow her to push
15 in a bunch of different positions.
16 Q As a general matter, do you think it was
17 below the standard of care to remove the monitor?
18 A Yes.
19 Q Is that because the monitor is that much
20 more accurate than intermittent auscultation?
21 A I think that intermittent auscultation only

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1 gives you a snapshot of the fetal heart rate at the
2 particular time you auscultate. And as we see, it's a
3 question of whether you're listening to the maternal
4 heart or the fetal heart. And so I think in the face
5 of a labor that was certainly showing variable to late
6 decelerations, this was not the time not to monitor
7 this patient for the last hour and 10 minutes, I
8 guess, or hour and 16 minutes.
9 Q Apart from your concern over whether they
10 were measuring the mother's or the fetal heart rate,
11 was there anything else in the recordings once
12 intermittent auscultation was used that leads you to
13 be concerned about the fetus?
14 A There's a nurse's note that with each push
15 more meconium is being seen. That's reconfirming my
16 earlier concern. At 6:15, the monitor is off by Susan
17 Beach, the fetal heart is checked by auscultation, by
18 listening, and that's when I find following the
19 nurse's notes quite difficult, because they are not in
20 sequence, which I commented on in one of my letters.
21 Q Of what you do see there in the chart,

17 (Pages 65 to 68)

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

3 A No.

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

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

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

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

7 A I'm going to assume that I had a baby with a
8 fetal heart, so I'm assuming that I have a recorded
9 fetal heart, that this was a fetal heart tracing,
10 although albeit it was an external monitor, and that
11 we would have at least had a baby with some Apgar at
12 that point. And as I've said to you, my concern is
13 that from -- again, that there was no consideration of
14 an operative vaginal or an operative delivery from
15 5:00 a.m. on.

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

18 A Yes.

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

21 A Yes.

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1 at that time, no, they continued.

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

5 A 6:10.

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

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

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

Page 72

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

3 A Yes.

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

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

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

12 A Yes.

13 Q Describe to what extent you feel that
14 infection contributed.

15 A In itself, I think chorioamnionitis in a
16 term fetus who has now been in labor over 23 hours has
17 to play on that baby's reserve. And I think that at
18 5:00, we were looking at a baby that had minimal to
19 any reserve left, was in fetal distress for whatever
20 reason, cord compression, chorioamnionitis for 20
21 hours, whatever. I don't think that baby could

18 (Pages 69 to 72)

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

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

9 A Sure it would have, absolutely.

10 Q How so?

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

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

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

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

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

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

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1 that all of the above.

2 Q All of the above would be possible?

3 A Would be possible, right.

4 Q As opposed to probable?

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

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

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

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

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

6 A Yes.

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

9 A No.

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

14 A Might.

15 Q It's possible?

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

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

19 (Pages 73 to 76)

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1 problems you would expect to see in a baby with
2 chorioamnionitis?
3 A Respiratory distress, certainly low Apgars
4 at birth, the possibility of a bowel infection of the
5 baby at birth, and pneumonia. But in a good level 2
6 or level 3 nursery, I think that these in a
7 noncompromised term baby, I think these could be
8 handled.
9 Q Do you have an opinion as to when the total
10 occlusion of the umbilical cord occurred in this case?
11 A No. Was that in the pathology? I missed
12 that if it was.
13 MS. TAYLOR-KOLIS: I would suggest to
14 you, Dr. Lowen, that if you want to look at the
15 autopsy that you can do that.
16 MR. RANKIN: Sure.
17 A Okay. I don't remember reading that. Let
18 me look. It doesn't say it was occluded. It doesn't
19 say there was a knot or anything here. So I'm
20 assuming that what you're asking me is because the
21 cord was around the neck, and she cut it. There was

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1 one loop of cord around the neck, and she cut it, and
2 that was the occlusion?
3 Q Right.
4 A We didn't go there.
5 Q That was implicit in my question. Do you
6 have an opinion as to when that occurred?
7 A No. Or if it occurred.
8 Q Or if it did?
9 A It was around the neck -- whether it was a
10 total occlusion or not.
11 Q I think there was some reference, either in
12 Susan Beach-Morgan's deposition, that it was a
13 tightened cord?
14 A One loop.
15 Q That doesn't necessarily mean --
16 A It doesn't occlude it. It certainly may
17 account for the tracings that we saw, and somebody
18 that's smarter than me will probably tell you that.
19 Q Would you agree that as of the time that
20 Susan Beach-Morgan assumed the care of this patient,
21 that up until that point in time the labor had been

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1 proceeding normally?
2 A Yes.
3 Q That's all I have. Thank you very much.
4 MR. RANKIN: Anybody have any
5 questions?
6 MR. HUFFMAN: I have no questions for
7 the witness.
8 (Off the record.)
9 MR. HUFFMAN: I don't think we need a
10 copy at this time.
11 MS. TAYLOR-KOLIS: Also, Dr. Lowen, you
12 have the right to read your testimony.
13 THE WITNESS: Yes. I would like to see
14 it written.
15 MS. TAYLOR-KOLIS: And I believe that
16 you should see it.
17 We are not going to waive his right to
18 read it. Send it to him, and I will take a regular
19 size copy.
20 (The deposition concluded at 12:02
21 p.m.)

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1 ACKNOWLEDGEMENT OF DEPONENT
2 I, Marc Lowen, M.D., do hereby acknowledge I
3 have read and examined the foregoing pages of
4 testimony, and the same is a true, correct, and
5 complete transcription of the testimony given by me,
6 and any changes and/or corrections, if any, appear in
7 the attached errata sheet signed by me.
8
9

10 Date Marc Lowen, M.D.
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21

20 (Pages 77 to 80)

Marc Lowen, M.D.

<div style="text-align: right; margin-bottom: 10px;">Page 81</div> <div style="text-align: center;"> <p>CERTIFICATE OF NOTARY PUBLIC</p> <p>I, Linda H. Cole, the officer before whom</p> <p>the foregoing deposition was taken, do hereby certify</p> <p>that the foregoing transcript is a true and correct</p> <p>record of the testimony given; that said testimony was</p> <p>taken by me stenographically and thereafter reduced to</p> <p>typewriting under my supervision; and that I am</p> <p>neither counsel for, related to, nor employed by any</p> <p>of the parties to this case and have no interest,</p> <p>financial or otherwise, in its outcome.</p> <p>IN WITNESS WHEREOF, I have hereunto set my</p> <p>hand and affixed my notarial seal this 26th day of</p> <p>December, 2002.</p> <p style="text-align: right;">My commission expires July 1, 2006</p> </div> <div style="text-align: center; margin-top: 20px;"> <p>_____ NOTARY PUBLIC IN AND FOR STATE OF MARYLAND</p> </div>	<div style="text-align: right; margin-bottom: 10px;">Page 83</div> <div style="text-align: center;"> <p>ESQUIRE DEPOSITION SERVICES</p> <p>401 E. PRATT STREET, SUITE 425</p> <p>BALTIMORE, MD 21202</p> <p>(410) 539-6398</p> </div> <div style="text-align: center; margin-top: 20px;"> <p>ERRATA SHEET</p> <p>Case Name: Yates v. MedCentral Health System, et al.</p> <p>Witness Name: Marc Lowen, M.D.</p> <p>Deposition Date: December 19, 2002</p> <p>Job No.: 149570</p> </div> <table style="width: 100%; margin-top: 20px;"> <thead> <tr> <th style="width: 10%;">Page No.</th> <th style="width: 10%;">Line No.</th> <th style="width: 40%;">Correction</th> <th style="width: 40%;">Reason for Correction</th> </tr> </thead> <tbody> <tr><td>9</td><td></td><td></td><td></td></tr> <tr><td>10</td><td></td><td></td><td></td></tr> <tr><td>11</td><td></td><td></td><td></td></tr> <tr><td>12</td><td></td><td></td><td></td></tr> <tr><td>13</td><td></td><td></td><td></td></tr> <tr><td>14</td><td></td><td></td><td></td></tr> <tr><td>15</td><td></td><td></td><td></td></tr> <tr><td>16</td><td></td><td></td><td></td></tr> <tr><td>17</td><td></td><td></td><td></td></tr> <tr><td>18</td><td></td><td></td><td></td></tr> <tr><td>19</td><td></td><td></td><td></td></tr> <tr><td>20</td><td></td><td></td><td></td></tr> <tr><td>21</td><td></td><td></td><td></td></tr> </tbody> </table> <div style="margin-top: 20px;"> <p>_____ Signature</p> <p>_____ Date</p> </div>	Page No.	Line No.	Correction	Reason for Correction	9				10				11				12				13				14				15				16				17				18				19				20				21			
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<div style="text-align: right; margin-bottom: 10px;">Page 82</div> <div> <p>December 26, 2002</p> <p>Marc Lowen, M.D.</p> <p>6701 Park Heights Avenue, Apt. 4G</p> <p>Baltimore, Maryland 21215</p> <p>Re: Yates v. MedCentral Health System, et al.</p> <p>Deposition of Marc Lowen, M.D.</p> <p>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.</p> <p>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.</p> </div>																																																									

21 (Pages 81 to 83)

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<p>A</p> <p>aberrant 16:1</p> <p>ability 52:1 74:13</p> <p>able 75:2</p> <p>abnormal 65:8</p> <p>above-referenced 82:6</p> <p>absolute 60:21</p> <p>absolutely 18:2 32:11 34:16 49:20 60:8,10 73:9</p> <p>acceleration 43:14 44:12</p> <p>accelerations 65:3</p> <p>acceptable 38:8,8 42:14</p> <p>accompanied 65:7</p> <p>account 78:17</p> <p>accurate 25:16,18 29:6 67:20</p> <p>acknowledge 80:2</p> <p>Acknowledgement 80:1 82:8,12</p> <p>ACOG 28:6</p> <p>acted 73:8</p> <p>action 13:20 41:2</p> <p>active 9:12 38:12,18 49:2 51:2 52:20</p> <p>actively 13:10,12,13</p> <p>activities 16:4</p> <p>actual 54:11</p> <p>acute 48:9,10</p> <p>add 50:2 61:20</p> <p>added 75:14,16</p> <p>additional 51:19</p> <p>Additionally 82:9</p> <p>adequate 55:21</p> <p>ADMIN 1:3</p> <p>administrative 13:9 14:5,16,17</p> <p>advertise 18:1</p> <p>advised 59:12</p> <p>affiliated 17:19</p> <p>affixed 81:12</p> <p>aggressive 62:6</p> <p>ago 5:11 6:5 8:16,18</p> <p>agree 38:11,21 49:16 55:10 62:10 64:14 70:16 72:1 78:19</p> 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